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ABSTRACT

The purpose of this hearing was to explore what is currently being done to educate school children about the increasing threat of acquired immune deficiency syndrome (AIDS). Inquiry was made into what is being done with grants from the Centers for Disease Control, and areas remaining to be dealt with were identified. Discussion centered on the sufficiency of the initial efforts by the Federal Government to create an effective AIDS education policy. Research literature about how to encourage responsible preventive behavior in children and young adults was discussed, and consideration was given to having more science, logic, and reason applied to the AIDS problem. A working draft of the New York City Board of Education AIDS curriculum and the Centers for Disease Control's "Guidelines for Effective School Health Education To Prevent the Spread of AIDS" education policy. are reprinted. (JD)

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OVERSIGHT HEARING ON EDUCATION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) IN ELEMENTARY AND SECONDARY SCHOOLS

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, FEBRUARY 3, 1988

Serial No. 100-63

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OVERSIGHT HEARING ON EDUCATION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) IN ELEMENTARY AND SECONDARY SCHOOLS

WEDNESDAY, FEBRUARY 3, 1988

HOUSE OF REPRESENTATIVES,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The committee met, pursuant to call, at 9:40 a.m., in Room 2175, Rayburn House Office Building, Hon. Major R. Owens presiding.

Members present: Representatives Owens, Biaggi, Hayes, Sawyer, Penny, Jeffords, Goodling, Petri, Gunderson, and Grandy.

Staff present: Bob Tate, legislative analyst; Alan Lovesee, counsel; Jack Jennings, counsel; Lawrence Peters, counsel; Maria Cuprill, staff director for Subcommittee on Select Education; Kirk Peterson, staff assistant; and Jeff Fox, assistant minority counsel; Andy Hartman, senior legislative associate, and Karen Coleman, minority staff assistant.

Mr. OWENS. The full Committee of the Education and Labor hearing will come to order.

Today's hearing is an oversight hearing on education on Acquired Immune Deficiency Syndrome in elementary and secondary schools.

There are now between a half million and a million-and-a-half people in the United States infected with the AIDS virus and all of the projections are for the epidemic to get much worse. Already the ninth leading cause of death in this country, somewhere between now and 1991 AIDs will overtake automobile accidents as the single largest cause of death in the 20 to 49 age group.

As a recent World Health Organization meeting has reminded us, we are dealing not just with a national but an international health care crisis.

Within this context, the United States, with the largest population of infected citizens and with the largest public health system in the world, ought to be in a position to lead global efforts to combat the disease.

Many European countries, with a far lower incidence of the disease than we have, have mobilized quickly to provide national media campaigns for their people and to give guidance in the area of education.

Children are particularly vulnerable to AIDs infection. The incidence of AIDS in children has doubled every three or four years.

Certain areas such as New York and New Jersey are facing significant health and foster care crises in dealing with this problem. In this context we need to develop comprehensive policies for treatment and prevention of AIDS in respect to children.

Senator Howard Metzenbaum and myself have introduced in the last session a bill that would address the needs of abandoned infants, many of whom have AIDS. Senator Metzenbaum's bill passed in the Senate; our bill is still under consideration here in the House.

I am pleased that the Chairman of the Education and Labor Committee, Chairman Hawkins, today has asked me to sit in and chair this meeting because this is a problem of particular concern to the Subcommittee on Select Education, which I chair.

As critical as a need for compassionate treatment of these infants is, the recent London Conference addressed education and information about AIDS as a single most important component of a national AIDS program, so education is as critical as treatment. In this endeavor we have failed to provide the necessary federal leadership to date.

It took at least five years from the time when AIDS was first diagnosed as a disease to the publication of the Surgeon General's Report on the Acquired Immune Deficiency Syndrome—a very good publication but rather tardy in its publication.

As a result of this report and the Surgeon General's personal fight within the administration for stronger action, the first significant commitment of Federal funds for AIDS education went out last night. The office that many naturally looked to for direction in the area of providing assistance to schools, that is the Department of Education, has abdicated its responsibility in this area.

An appropriate role for the Department of Education would involve working with the Centers for Disease Control in promoting coordinated approaches by State Education and Health Departments. Instead, the Department's primary effort has been devoted to the publication and dissemination of its booklet entitled "AIDS and the Education of Our Children." This publication is notable chiefly for its lack of balance and polemical tone which has tended to generate more heat than light in helping parents and teachers deal effectively with their questions about the disease.

Partly as a result of the Education Department's failure to take a responsible role in this issue, Congress has provided in House and Senate versions of H.R. 5—the bill still under consideration—a provision for an Office of Comprehensive School Health Education inside the Department of Education. The creation of this office might be sufficient stimulus to the administration to make the Department of Education fulfill a much needed role in AIDS education.

Let us hope today that we can begin to look ahead at what can possibly be achieved in the area of education when resources are properly directed. We must ensure when we look at school health programs that they are part of a comprehensive health curriculum and that information about AIDS is not given in a piecemeal fashion.

All other sexually transmitted diseases also need to be included within a K to 12 curriculum. Additionally, we ought not to forget

that there is a large population of out-of-school youth. In many urban centers the dropout rate is 50 percent. These individuals are equally if not more at risk than those who are still in school.

The purpose of today's hearing is to explore what currently is being done with the grants that have been let by the Centers for Disease Control and to identify what areas remain to be dealt with.

How can we begin the task of educating a whole new generation about this disease? And in doing so, how can we prevent more wasting of young lives to the epidemic?

Has this initial effort been sufficient?.

And what are the effective ways of fostering local community development of AIDS curriculum?

What does the research literature suggest about how to encourage responsible preventive behavior in children and young adults?

How can we have more science, logic, and reason applied to this problem?

And how can we minimize emotional excesses and hysteria?

In discussing AIDS education policy we need to get past the debate over condoms versus abstinence. We need to talk, rather, in terms of a public health crisis that we neglect at our peril.

It is time to call for a decade of action on AIDS; a decade that is characterized by reasons rather than emotions; a period in which the Federal, State and local governing bodies working together will try to reach as many students as possible; a decade in which Congress and the administration make it their priority to fight ignorance and misinformation about the disease, and to begin to finally turn the corner on this dreadful epidemic.

I yield to Congressman Jeffords for an opening statement.

Mr. JEFFORDS. Thank you, Mr. Chairman, I appreciate your concern and your efforts in this area.

We are here today as is rather obvious is that we are painfully aware that AIDS is the most threatening and disastrous disease as we have faced in our lifetime. What makes this so tragic, apart from the obvious, is that unlike virtually any other epidemic in history, we have within our power the ability to stop the spread of AIDS right now if only people change their behaviors.

The only way they can do that, however, is that they fully understand the connection between their personal behavior and their health—and that is where education comes in. Hopefully, we will see an AIDS vaccine and treatment in the not too distant future, but that does not seem very likely right now.

But for right now we must rely upon what we have, and the only real weapon we do have right now is education—teaching people how to avoid getting the disease.

The focus of this hearing is on the role that schools could, and should, play in this educational effort to prevent the spread of AIDS.

I would hope that as a result of this forum we would have a clearer and more comprehensive picture of the current efforts to educate students about AIDS, how they are being implemented at the Federal, State and local levels.

Congress should assume a more active leadership role in this effort by providing both the necessary funding and appropriate guidance for successful education programs. More schools across

this Nation would see that others are doing and understand that AIDS education programs can be implemented and that they are acceptable to their community.

Finally, that we might learn from past experience and have a better idea about where future efforts should be directed.

Any successful AIDS education program must be part of a more comprehensive education program that teaches students over a number of years about how the human body functions and about the importance of maintaining one's health. If any good at all occurs as a result of this tragic disease it is that schools and other organizations will seriously address the need for health education—and that will contribute to the prevention not only of AIDS but of other pervasive problems facing our youth, including drug use, pregnancy, and violence.

I look forward to listening to the witnesses today and hope that we may play a role in helping to prevent the spread of AIDS.

Thank you, Mr. Chairman.

Mr. OWENS. Do any other members have opening statements?

Mr. Penny?

Mr. PENNY. No.

Mr. OWENS. Mr. Goodling?

Mr. GOODLING. No.

Mr. OWENS. Mr. Hayes?

Mr. HAYES. I defer my time, Mr. Chairman.

Mr. OWENS. Yes, Mr. Grandy?

Mr. GRANDY. Thank you, Mr. Chairman.

I don't really have a formal opening statement.

I would just hope that in our preliminary discussions today and in this testimony and in this research endeavor we do not exclude or preclude the role of parents in this educational process.

Even in rural communities that I represent, the lack of information and understanding really begins at home and the family unit. And if we don't make the parents our allies instead of our adversaries in this particular educational process, it doesn't make much difference what the schools do if it is undone when the children go home.

With that note, I hope that our witnesses today will provide some edification on that score.

I yield back.

Mr. OWENS. On the distinguished list of panelists today are Mr. Dennis D. Tolsma of the Center for Health Promotion and Education, Centers for Disease Control, Atlanta, Georgia. Mr. Tolsma is accompanied—and they are available for questions—by Mr. Lloyd J. Kolbe of the Office of School Health and Special Projects of the CDC; Mr. Jack T. Jones, Program Coordinator, School Health Education to Prevent the Spread of AIDS, CDC, and Dr. Peter Drotman, Medical Epidemiologist from the CDC.

We also have Ms. Connie Hubbell, Deputy Executive Director, National Association of State Boards of Education, Ms. Gerri Abelson, New York City Board of Education, Office of Health, Physical Education and School Sports, and Dr. Wanda Jubb, of the Michigan Department of Education, School Programs and Services, from Lansing, Michigan.

We would like for you to begin, Dr. Tolsma.

STATEMENTS OF DENNIS D. TOLSMA, DIRECTOR, CENTER FOR HEALTH PROMOTION AND EDUCATION, CENTERS FOR DISEASE CONTROL, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY LLOYD J. KOLBE, CHIEF, OFFICE OF SCHOOL HEALTH AND SPECIAL PROJECTS, CDC; JACK T. JONES, PROGRAM COORDINATOR, SCHOOL HEALTH EDUCATION TO PREVENT THE SPREAD OF AIDS, CDC, AND PETER DROTMAN, M.D., CENTER FOR INFECTIOUS DISEASES, CDC; CONNIE HUBBELL, MEMBER, KANSAS STATE BOARD OF EDUCATION, ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION, ALEXANDRIA, VA, AND THE KANSAS STATE BOARD OF EDUCATION, ACCOMPANIED BY KATHERINE FRASER, CO-DIRECTOR, AIDS EDUCATION PROJECT, NASBE; GERRI ABELSON, NEW YORK CITY BOARD OF EDUCATION, OFFICE OF HEALTH, PHYSICAL EDUCATION AND SCHOOL SPORTS, BROOKLYN, NY, AND WANDA JUBB, MICHIGAN DEPARTMENT OF EDUCATION, SCHOOL PROGRAMS AND SERVICES, LANSING, MI

Mr. TOLSMA. Thank you, Mr. Chairman.

I am pleased to represent CDC in discussing our efforts to help provide effective education to prevent the spread of AIDS and human immunodeficiency virus among our Nation's youth. I will use the term HIV when I refer to human immunodeficiency virus and I will briefly summarize my testimony and submit the full testimony for the record.

Before addressing the AIDS problem in relation to our young people some background on the magnitude of the epidemic might be helpful.

By January 25, 1988, a cumulative number of AIDS cases reported to CDC from all 50 States, the District of Columbia, and the territories was 51,916.

The cumulative number of reported AIDS cases in children is 781, or one percent of the cases.

The approximately 50,000 persons with AIDS, of whom about 29,000 have already died, represent a small portion of the one to 1½ million Americans who are estimated to be infected with HIV virus.

Among homosexual and bisexual men, the prevalence of HIV infection varies from about 10 percent to 70 percent, while prevalence among IV drug users varies somewhat more widely, from 0 to 60 percent, depending very importantly on the geographical site and the study population.

These largely asymtomatic infected people are very important from a public health perspective because they are capable of transmitting HIV virus.

Prevention information has been disseminated in homosexual communities and there is evidence that sexually transmitted diseases have declined in those communities. This decline suggests that positive behavior change has taken place. Such information is lacking at this point for IV drug users and for their heterosexual partners. CDC is undertaking expanded surveillance of HIV which should provide insights about heterosexual spread.

In terms of the future, we project that by the end of 1991 the number of AIDs cases will total more than 270,000. The number of AIDS-related deaths at that point will be more than 179,000. Of the 270,000 projected cases, more than 3,000 will have been diagnosed in infants and children.

We know the causal vehicles for spread. They are the same as they have been since the early days of the epidemic: they are behavioral. The significant number of teen-agers engaged in behaviors have increased their risk of being infected with HIV.

In metropolitan areas, more than half of never-married females and about two-thirds of never-married males report that they have engaged in intercourse by the time they are 18 years old.

CDC estimates that 2.5 million cases of sexually transmitted diseases occur each year among teen-agers and that teen-agers experience about one million pregnancies each year. Some teen-agers also are at risk of becoming infected with HIV through illicit intravenous drug use.

Findings from a national survey conducted in 1986 of nearly 130 high schools indicated that although overall illicit drug use seems to be declining slowly among high school seniors, about one percent of seniors reported having used heroin and 13 percent having used cocaine within the previous years. Some forms of cocaine are injectable. The number of seniors who injected each of these drugs, however, is unknown. Clearly, many adolescents are practicing behaviors that put them at increased risk of acquiring HIV. For those adolescents not practicing these behaviors, it is essential to reinforce the continuation of positive health behavior.

Although only two percent of all persons diagnosed with AIDS have been under the age of 20, about 21 percent of all persons diagnosed with AIDS have been 20 to 29 years old. Since there is a long incubation period between acquisition of the virus and development of AIDS, it would seem likely that a significant number of these 20 to 29-year-olds in fact acquired their infection while they were in their teen years.

Within the Public Health Service, CDC is the lead agency for AIDS information, education, and risk reduction activities, currently the primary intervention strategy is available to us. We have implemented a comprehensive program designed to prevent the spread of AIDS and HIV infection. The program includes surveillance and epidemiologic studies, and information and education programs directed towards several target populations: the general public, school and college age youth, persons at increased risk of infection, and health workers.

These latter four components of our prevention program conform to the major elements of the "Information and Education Plan to Prevent and Control AIDS in the United States" issued in March of last year.

In 1987, CDC spent $136 million on AIDS, and in 1988, our budget for preventing the spread of AIDS and HIV infection is $304.9 million.

It is important that we attack the Nation's number one public health problem with a comprehensive, integrated program that is based on behavioral and educational research, and on the coopera-

tion of the health community, the education community, the private sector, and voluntary agencies.

School health education plays a critical role in that effort to reduce the risk in our Nation's young people. We have worked for many years with schools in the area of improving the health of young people.

With this background, in 1987, we launched a program to help the Nation's schools and other private sector national organizations interested in health and education to provide education. We spent about $11 million last year on this program. In 1988, the budget for this program is $29.9 million. It is built on working relationships with State and local education departments, health departments, and other organizations, and targets youth both in and out of school.

I am very pleased to see that the panel has people representing this component of society because they are the ones who carry out the education and it is their testimony which will be quite important to you.

Just very briefly, we provide financial and technical assistance to 15 State and 12 local departments of education. These were the areas with the highest cumulative incidence of AIDS cases.

To extend the impact of this program and to help States not supported by CDC we have also awarded additional cooperative agreements to the Michigan State Department of Education, the New York State Department of Education, and the San Franciscso Unified School District. Each of these will work as training and demonstration sites, which will help other school personnel across the country.

We are also assisting State and local health departments to enhance their cooperation with their education department counterparts.

We are working with 15 national private sector organizations. These are organizations who have a capacity, the constituencies, and the experience to help schools in all communities across the Nation. We have provided lists of these to the committee and I won't enumerate them but I do want to indicate to you that they include groups focusing on professional organizations that represent education and health education people. They include groups who specifically will be working to provide and advance education for minorities, and groups that represent the interests of out-of-school youth.

Finally, we have a component of the program that involves the dissemination of information. We have established a bibliography of resources to allow anyone with a personal computer and a modum to be able to access what is known and what is being published on AIDS material, so they may make a choice about what they wish to use at the State and local level.

In closing, let me mention that CDC has issued two guidelines in this area. The first was "Guidelines for Education and Foster Care of Children with HIV" on August 30, 1985, and on January 29, 1988—last Friday—CDC published "Guidelines for School Health Education to Prevent the Spread of AIDS."

These latter guidelines were developed to assist people. They are not in any way a mandate on what should be done; rather, they

were a consensus from a broad cross-section that included medical community, the public health and education community, representative of religious orientation, and the U.S. Department of Education and the National Education Association, among others.

With that, Mr. Chairman, I will close my testimony.

[The prepared statement of Dennis D. Tolsma follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

STATEMENT OF

DENNIS D. TOLSMA, M.P.H.

DIRECTOR

CENTER FOR HEALTH PROMOTION AND EDUCATION

CENTERS FOR DISEASE CONTROL

PUBLIC HEALTH SERVICE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

COMMITTEE ON EDUCATION AND LABOR

UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 3, 1988

Mr. Chairman and Members of Committee:

I am Dennis Tolsma, Director of the Center for Health Promotion and Education, Centers for Disease Control (CDC). I am pleased to represent CDC in discussing our efforts to help provide effective education to prevent the spread of AIDS and human immunodeficiency virus infection among our Nation's youth. Accompanying me are Dr. Lloyd Kolbe and Mr. Jack Jones of the Center for Health Promotion and Education, and Dr. Peter Drotman of the Center for Infectious Diseases.

Before addressing the AIDS problem in relation to our young people, some background on the magnitude of the AIDS epidemic may be helpful. By January 25, 1988, the cumulative number of AIDS cases reported to CDC from all 50 States, the District of Columbia, and the territories was 51,916. Of these, 33,190 (65 percent) cases have occurred in homosexual and bisexual men, and 8,791 (17 percent) cases have occurred in heterosexual IV drug users. Another 3,386 (8 percent) cases have been in homosexual IV drug users. The cumulative number of reported AIDS cases in children is 781 (1 percent) cases. The remaining cases include such categories as hemophiliacs, blood transfusion recipients, heterosexual related transmissions, and cases under investigation.

The approximately 50,000 persons with AIDS (about 29,000 of whom have died) represent a small portion of the one to one-and-a-half million Americans who are estimated to be infected with the human immunodeficiency virus (HIV) that causes AIDS. Among homosexual and bisexual men, the prevalence of HIV infection varies from about 10 percent to 70 percent while prevalence among IV drug users is estimated to vary from 0 to 60 percent, depending on geographical site and study population.

These largely asymptomatic infected people are very important from a public health perspective as they are capable of transmitting HIV. Prevention information has been disseminated in homosexual communities, and there is some evidence that sexually transmitted diseases have declined in those communities. This decline suggests that positive behavior changes have taken place. However, such evidence is lacking for IV drug users and their heterosexual partners. There is no infection trend information yet available to evaluate whether the risk is rising for exclusively heterosexual persons who do not abuse drugs and who are not knowingly partners of persons with or at risk of HIV infection. We are undertaking expanded HIV surveillance which should provide insights about heterosexual spread.

We project that, by the end of 1991, the number of AIDS cases will total more than 270,000, and the number of AIDS-related deaths more than 179,000. Of the 270,000 projected cases, more than 3,000 will have been diagnosed in infants and children.

HIV is spread principally by sexual intercourse with an infected person, by using needles or other injection equipment that an infected person has used, and from an infected mother to her infant before or during birth. Because the virus is spread almost exclusively by behaviors that individuals can modify, educational programs to influence these behaviors can be effective in preventing the spread of HIV. The Centers for Disease Control, the National

Academy of Sciences, the Surgeon General of the United States and the U.S. Department of Education have noted that in the absence of a vaccine or therapy, educating individuals about actions they can take to protect themselves from becoming infected is the most effective means available for controlling the epidemic.

A significant number of teenagers engage in behaviors that increase their risk of becoming infected with HIV. In metropolitan areas more than half of never-married females, and about two-thirds of never-married males, report that they have engaged in sexual intercourse by the time they are 18 years old. CDC estimates that about 2.5 million cases of sexually transmitted disease occur each year among teenagers, and that teenagers experience about one million pregnancies each year. Some teenagers also are at risk of becoming infected with HIV through illicit intravenous drug use. Findings from a national survey conducted in 1986 of nearly 130 high schools indicated that although overall illicit drug use seems to be declining slowly among high school seniors, about 1% of seniors reported having used heroin and 13% reported having used cocaine within the previous year. The number of seniors who injected each of these drugs is unknown. Clearly, many adolescents are practicing behaviors that put them at increased risk of acquiring HIV. For those adolescents not practicing such behaviors, it is essential to reinforce the continuation of positive health behaviors.

(3)

Although only 2% of all persons diagnosed with AIDS have been under age 20, about 21% of all persons diagnosed as having AIDS have been 20-29 years old. Given the long incubation period between HIV infection and the appearance of symptoms leading to the diagnosis of AIDS (averaging about 5 years), the majority of those in the younger group aged 20-to-25 years at the time of diagnosis were most likely infected while they were teenagers.

Within the Public Health Service, CDC is the lead agency for AIDS information, education, and risk reduction activities, currently our only prevention interventions. In carrying out this responsibility, we have implemented a comprehensive program designed to prevent the spread of AIDS and HIV infection. This AIDS prevention program includes surveillance and epidemiologic studies, and information and education programs directed toward the general public, school and college-aged youth, persons at increased risk of infection, and health workers. These latter four components of our prevention program conform to the major elements of the PHS "Information/ Education Plan to Prevent and Control AIDS in the United States." (A copy of the Plan is being provided to the Committee.) In 1987, CDC spent $136.0 million on AIDS, and in 1988, our budget for preventing the spread of AIDS and HIV infection is $304.9 million. It is important that we attack the nation's number one public health problem with a comprehensive, integrated program that is based on behavioral and educational research, and on the cooperation of the health community, the education community, the private sector, and voluntary agencies.

School health education plays a critical role in our effort to reduce the risk to our Nation's young people of HIV infection. CDC enjoys a long history of working with the Nation's schools to protect and improve the health of young people. With this background, in 1987, CDC launched a program to help the Nation's schools and other private sector national organizations provide education that could be effective in preventing the spread of AIDS. In 1987, we spent $11.1 million on our efforts to prevent AIDS and HIV infection among school and college-aged youth. In 1988, our budget is $29.9 million. The program is built on working relationships with State and local education departments, health departments, and other organizations, and targets youth both in and out of school. The program comprises several complementary strategies.

CDC is providing financial and technical assistance to 15 State and 12 local departments of education in jurisdictions with the highest cumulative incidence of AIDS. (A copy of the list of recipients is being provided to the Committee.) We are working with these State and local departments of education, and their respective State and local health departments, to ensure that young people in their jurisdictions receive effective AIDS education. During this fiscal year, 1988, we plan to extend this assistance to all State departments of education, and to expand the support currently being provided.

(5)

To extend the impact of the AIDS school health education effort, CDC has awarded cooperative agreements to the Michigan State Department of Education, the New York State Department of Education, and the San Francisco Unified School District to enable each to establish a national AIDS education training center. These agencies were selected competitively from among eight that applied. Personnel from State and local departments of education across the Nation will be able to attend one of these three centers to receive training and technical assistance to help them plan and implement AIDS education programs in their own jurisdictions.

CDC also is assisting State and local health departments to enhance cooperation with their education department counterparts in implementing effective AIDS education programs, including education to prevent the spread of other sexually transmitted diseases and to prevent intravenous drug abuse. CDC is working with 15 national private sector organizations with the capacity, constituencies, and experience to help schools in communities across the Nation provide effective AIDS education.

- To engage the Nation's local school boards, school administrators, and rural and small schools, we have awarded cooperative agreements to the National School Boards Association, the American Association of School Administrators, and the National Rural & Small Schools Consortium.

- To work through the Nation's school nurses, physicians, health educators, counselors, teachers, and parents, cooperative agreements have been established with the American School Health Association and the National Congress of Parents and Teachers (the PTA).

- We are working to promote appropriate education about AIDS for Black and Hispanic youth through cooperative agreements with the National Coalition of Hispanic Health and Human Service Organizations, the National Organization of Black County Officials, and the Association for the Advancement of Health Education.

- To help address the needs of youth not in school, we have implemented cooperative agreement activities through the National Association of Runaway & Youth Shelters, and through the National Coalition of Advocates for Students.

- We have a cooperative agreement with the American College Health Association to assist colleges and universities in providing effective education about AIDS for their students.

- To help train school personnel across the Nation in implementing effective AIDS education programs, we have cooperative agreements with Education, Training, & Research, Inc., and the Center for Population Options.

- Finally, we are working with the Nation's State school superintendents and State school boards through the Council of Chief State School Officers and the National Association of State Boards of Education respectively.

CDC is helping to develop and disseminate educational resources. As part of this strategy, we have established a computerized bibliography that currently describes more than 400 resources for AIDS education and how to obtain them. The bibliography, which has been established as part of the U.S. Public Health Service's Combined Health Information Database (CHID), is accessible through a vendor to anyone who has a microcomputer and modem. This bibliography of AIDS education resources is updated every three months, and includes descriptions of AIDS-related curricula, school programs, out-of-school programs, policies, films and videotapes, filmstrips, audiotapes, teacher training programs, books, journal articles, parent materials, brochures and posters, and other materials.

CDC published "Guidelines for Education and Foster Care of Children with HIV" on August 30, 1985, that have been widely used by schools to establish policies for students who are infected with HIV. More recently, on January 29, 1988, CDC published "Guidelines for School Health Education to Prevent the Spread of AIDS." (These guidelines are being provided to the Committee.)

(8)

Since these latter Guidelines reflect the philosophy that drives our efforts, let me elaborate on them. The Guidelines were developed in consultation with representatives from 15 national organizations. Among the organizations represented were the American Academy of Pediatrics, the Association of State & Territorial Health Officers (representing the Nation's State health commissioners), the Council of Chief State School Officers (representing the Nation's State school superintendents), the National Council of Churches, the National Education Association, the U.S. Department of Education, and others. These Guidelines incorporate the principles for AIDS education that were developed by the President's Domestic Policy Council by recommending that the scope and content of school health education about AIDS should be locally determined and consistent with parental and community values. In summary, these Guidelines offer nine recommendations.

1. Parents, teachers, students, and appropriate community representatives should be involved in developing, implementing, and assessing AIDS education policies and programs.

2. AIDS education should be developed as an important part of a more comprehensive school health education program.

3. Education about AIDS should be taught by regular classroom teachers in elementary grades, and by qualified health education teachers or other similarly trained personnel in secondary grades.

(9)

4. AIDS education programs should help students acquire essential knowledge to prevent HIV infection at each appropriate grade. (The Guidelines identify appropriate knowledge about AIDS for early elementary students, for late elementary/middle school students, and for junior high/senior high school students.)

5. AIDS education programs should describe the benefits of abstinence for young people, and mutually monogamous relationships within the context of marriage for adults.

6. Education about AIDS should be designed to help teenaged students avoid specific behaviors that increase the risk of becoming infected with HIV.

7. Training about AIDS and AIDS education should be provided for school administrators, teachers, nurses, and counselors, especially those who teach about AIDS.

8. Sufficient program development time, classroom time, and educational materials should be provided for education about AIDS.

9. The processes and outcomes of AIDS education should be monitored and periodically assessed.

In addition, CDC has provided assistance to State health departments, universities, and private organizations for developing scientifically-valid instructional materials about AIDS and other sexually transmitted diseases (STDs). These materials include: STD: A Guide for Today's Young Adults; AIDS: What Young Adults Should Know; and a computer-assisted tutorial about AIDS and other sexually transmitted diseases for junior and senior high school students. We worked closely with the American Council of Life Insurance and the Health Insurance Association of America to develop a brochure for teenagers that those organizations are now disseminating. The brochure is called Teens and AIDS: Playing It Smart. (A copy of each of these materials is being provided to the Committee.)

CDC is also convening national working meetings. In November 1987, we convened representatives from 13 Federal agencies conducting educational programs or behavioral research to prevent the spread of HIV among youth. This meeting helped us to coordinate our efforts with those of other Federal agencies. On February 1 and 2, 1988, CDC convened the first National Meeting on School Health Education to Prevent the Spread of AIDS. More than 200 of the Nation's leaders attended this meeting, including representatives of State and local departments of education, State and local health departments, national education and national health organizations in the private sector, and various Federal agencies. This meeting provided an opportunity to explore and discuss efforts related to AIDS education.

On May 25-27, 1988, health education directors in every State department of education and every State department of health are invited to meet together to discuss the integration of AIDS education within the more comprehensive school health education program.

We have also provided support to revise two comprehensive school health education curricula to address AIDS. These curricula, the Growing Healthy elementary school curriculum and the Teenage Health Teaching Modules secondary school curriculum, are the most widely used comprehensive school health education curricula. A broadly-based national panel has been established to assist in the development of these revisions.

Finally, research and evaluation is an essential underpinning to effective education intervention. Consequently, we are working with each of the 15 national organizations, as well as the 15 State and 12 city departments of education that we currently are funding to help them evaluate, and consequently improve, the impacts of their programs. As part of the National Adolescent Student Health Survey that was conducted last fall, we have gathered baseline information about the AIDS knowledge and beliefs of the Nation's eighth and tenth grade students. The national data generated is being used by program managers to plan their educational strategies in AIDS school health education. State and local education agencies are establishing systems to obtain baseline information, and, most importantly, to monitor AIDS-related knowledge, beliefs,

and/or behaviors among selected samples of youth in order to plan and assess the effectiveness of their educational strategies in reducing risk behaviors among adolescents. In addition, we awarded a contract to the National Academy of Sciences to synthesize existing behavioral research that might help us develop more effective educational interventions, and to suggest a framework and agenda for priority behavioral research to control the AIDS epidemic.

In conclusion, Mr. Chairman, CDC is building a national program to prevent the spread of HIV infection among our Nation's young people. Success in reaching young people at risk will require that health and education agencies at the national, State, and local levels work closely together. It is not an easy task to influence our Nation's youth to adopt or maintain the skills and behaviors they will need to avoid becoming infected with the AIDS virus, but the accomplishment of that task is vital to the well-being of our young people and to our Nation.

I will be happy to answer any questions you or members of the Committee might have.

(13)

Mr. OWENS. Thank you.

Ms. Hubbell?

Ms. HUBBELL. Thank you, Mr. Chairman, members of the committee.

I am Connie Hubbell. I would like to state that I am a member of the Kansas State Board of Education and serve as a board member of the National Association of State Boards of Education. I am not a staff member of the NASBE organization. I am here representing both the State Board of Education from Kansas and the National Association of State Boards of Education. I was appointed on Kansas Governor Mike Hayden's Task Force to look at AIDS and we have submitted a report to the Governor of Kansas on the issue of AIDS education. I serve as the Chairman of the Education Subcommittee of that AIDS Task Force.

I am delighted this morning to be representing both the Kansas State Board of Education and the National Association of State Boards of Education. I will give you portions of my testimony that you have written in front of you.

I would like to begin this morning by reading a letter to you, one of hundreds received by our National Association. It states:

To whom it may concern:

I am a student at Barbers High School in Mont Belvieu, Texas. Right now in my home economics class we are talking about AIDS. I do not understand AIDS and I do not believe in it either. I have been reading in a magazine about AIDS. I would really be pleased if you would send me some information on AIDS.

This is one of hundreds of letters—letters from elementary school students, from high school students, teachers, school nurses, principals, school board members, and State policymakers—all requesting different types of information about AIDS, from details about the disease, to curricula materials, to model policies dealing with students and staff who are infected. No one who had to answer this volume of mail could doubt that there is a crucial need for information in this area.

As you are aware, State board members are volunteers. We represent a variety of occupations, and I believe that we are in a unique position to build a consensus among parties seeking to have an impact on issues and policies on issues of AIDS.

The National Association of State Boards of Education—NASBE—has received $154,000 cooperative agreement this year from the Centers for Disease Control. Our objects are to help States develop or strengthen policies to prevent the spread of AIDS. The project has two parts.

First, NASBE will develop and distribute a Policymaker's Guide to Effective AIDS Education.

Second, NASBE will give direct technical assistance to policymakers in seven States this coming year.

In December, as part of its CDC project, NASBE conducted a State-by-State survey of actions to promote AIDS education in all States of the United States. The survey indicated that currently there are 18 States now who require AIDS instruction. This number has more than tripled just since June of last year.

States requiring AIDS education are located in all parts of our country, in both large and small States, large and small cities.

These policies vary in content and comprehensiveness, though all do allow parents the option to exempt their children from any portion of that instruction that they so choose.

Some State policies require community involvement and they do encourage parent education.

Some specify the grade levels at which the instruction must occur. And seven of the 18 States do require that AIDS education be provided at the elementary level. Seventeen States have developed instructional materials or guidelines. Currently, Alabama is the only State with a mandatory statewide AIDS curriculum.

Some States, although very active in their AIDS education, have not required AIDS education yet in their State. There do still remain a large number of gaps.

Few States have provided funding from their Department of Education to the AIDS education. Many States do not have what we call comprehensive plans. Few States have addressed the problem of educating youth who are at high risk of infection. Few have plans for evaluating and monitoring the AIDS education in the local schools in their State.

We believe that States should respond quickly and powerfully to this health epidemic. Yet it is a formidable challenge to design these policies that will address the barriers to providing effective AIDS education. Those barriers would include:

We must dispel public misconceptions regarding AIDS and our education programs.

We must be available to have rapidly changing facts for those classrooms.

We must address the lack of consensus about what should be taught and how it should be taught.

We must be prepared to take care of the lack of qualified teachers in this area.

There is local reluctance to provide AIDS education in light of the controversy surrounding sex education.

There is difficulty for State level policymakers to have an impact at the classroom activities.

This year, additional States will consider whether to require AIDS education in their curriculum programs.

We are concerned that some proposals may be made in an atmosphere of fear and urgency. The National Association of State Boards of Education is concerned that these policies must be comprehensive, not reactionary.

In November of 1987, the Kansas State Board of Education required schools to provide AIDS education by this coming September, 1988 at the elementary and secondary level. We have provided for our local schools in Kansas a comprehensive plan for providing the AIDS education to our students. This effort was initiated in the Fall of 1986 when a Conference on Teen-age Pregnancy was held in the State of Kansas.

Despite our State's history of strong local control, everyone at the Conference agreed that sex education should and must be required.

After studying the issue, the State Board of Education in Kansas voted in May of 1987 to preliminarily approve a mandate for both sex and AIDS education in our public schools. Following that man-

date, a series of public hearings were held in order to receive input from our public.

Before the State Board acted, few districts were offering AIDS education because of the local pressure opposing it. For that reason they were in favor of a State requirement that education about AIDS must be provided. I still don't believe that very many local districts would be teaching about AIDS education had the State not put this mandate upon them.

There was strong opposition before the first vote in May of 1987. Board members in our State were receiving 100 letters a day against any mandate on AIDS education.

We launched a public information campaign stressing that we were not promoting safe sex, but we were promoting education about this incurable, fatal disease—and it worked. From May until November, when we had our final vote, letters of support poured in from our parents, our teachers, the general public, showing that they understood that this was a very important issue.

I would like to read one letter that I received in September. It stated:

"Dear Mrs. Hubbell:

As a high school counselor in a small school, I fully support the Kansas State Board of Education in its mandate for AIDS education. The young people in our school have a lack of understanding and an embarrassment that keeps them from seeking the help they so desperately need. Properly trained teachers are the best source of a comprehensive AIDS education program—to not only dispel fears, but also to instill responsible decisionmaking in today's youth. I fully support your effort on behalf of the welfare of all Kansas. Please continue your efforts."

In October, the State Board of Education held its final public hearing on this issue. Forty people testified, and over three-fourths of those people testified in support of the policy to mandate AIDS education in our schools. As a result, the State Board of Education in November of 1987 voted almost unanimously to formally change Kansas' rules and regulations to require both sex education and AIDS education in all accredited elementary and secondary schools by September of 1988.

Under our requirements, the local schools will decide who will teach about AIDS, what will be taught, and when it will be taught. Most of the decisions have been left up to the local board of control in each local district. It is, and it must be, a community decision. It is the State's responsibility to provide enough information so that those local school boards will make informed decisions on what curriculum should be included.

Our conservative midwestern State doesn't have the AIDS cases that States with large urban areas have. Only one Kansas student has died of AIDS. The fact that we did mandate sex education and AIDS education in our schools should show the American people how important this issue is. In Kansas, we saw the need and took action before we had an epidemic in our State. We mandated AIDS education because Kansans are convinced that there is no other way to stop this terrible disease.

We want our AIDS education program to calm students' fears. Our goal is to promote abstinence and fidelity—to give children the confidence to say no to illegal drugs, to premarital sex. We want to address other health issues like teen suicide and teen pregnancy as well as to prevent AIDS. It is, and it will be, a comprehensive health program.

AIDS education belongs in a broader context. If we want our programs to have a long-term impact on our children's health, they must be well planned and monitored from kindergarten through high school. But if schools don't already have a comprehensive health program they can't afford to wait. Young people need information about AIDS now.

The National Association of State Boards of Education and the Centers for Disease Control are involved in a long-term effort to build the capacity of State and local agencies to improve school health programs. This is a good example of how education and health agencies should, and can, and are working together.

I want to impress and stress the importance of effective AIDS education programs—programs that don't stop with just providing information, but are designed to affect the attitudes and the behaviors of our students. Students must reach out to parents and to the community for help in reinforcing the message students get at school so they can make good decisions—good, healthy decisions.

State leadership is an important tool for fighting this epidemic. State Boards of Education can take the heat and to educate the public so that the same battles aren't fought over and over at the local levels.

In Kansas, Governor Hayden was 100 percent behind the State Board's efforts to provide AIDS education. He has proposed $1½ million in his appropriation for the 1988 legislature to consider to be given directly to local schools in AIDS education. That would average around $3.75 per student in the Kansas schools to help those local school boards develop curriculum and in-service their teachers so they are able and ready to teach about AIDS.

Many States have not yet taken this leadership. Perhaps some policymakers think that AIDS will never be a serious problem in their State. But one in every seven teen-agers gets a sexually transmitted disease each year, and all of these youngsters are at risk of an AIDS infection. We cannot take chances with our children's lives—education is the only tool.

I would like to express my sincere appreciation for having the opportunity to talk with you this morning. The National Association of State Boards of Education and its State boards members stand ready to work with you in confronting this very difficult health issue.

Thank you.

[The prepared statement of Connie Hubbell follows:]

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TESTIMONY
BEFORE THE HOUSE
EDUCATION AND LABOR COMMITTEE
BY
CONNIE HUBBELL
FOR
THE NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION
ON
ACQUIRED IMMUNE DEFICIENCY SYNDROME
IN ELEMENTARY AND SECONDARY SCHOOLS

Executive Director

Good morning, Mr. Chairman and members of the Committee. My name is Connie Hubbell, and I am a member of the Kansas State Board of Education. I am also a member of the Board of Directors for the National Association of State Boards of Education (NASBE). I am a mother, a very active volunteer, and a former teacher. I was elected to the Kansas Board of Education in 1984 and have served as the Legislative Chair for the Board since 1985. I was appointed as a member of Governor Mike Hayden's Task Force on AIDS in 1987 and served as the Chair of the Education Subcommittee of that Task Force. The Task Force made a 100-page report to the Governor in December of 1987, addressing a wide range of AIDS-related concerns, including health care, education, and AIDS in prisons, state institutions, and in the workplace.

I am delighted to be here this morning representing NASBE and the Kansas State Board. I would like to begin by reading you a letter, one of hundreds received by NASBE.

> "To whom it may concern:
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> I am a student at Barbers Hill High School in Mont Belvieu, Texas. Right now in my home economics class we are talking about AIDS. I do not understand AIDS and I do not believe in it either. I have been reading a magazine about AIDS. I would really be pleased if you would send me some more information."

This is one of hundreds of letters -- letters from elementary school

children, high school children, teachers, school nurses, principals, school board members, and state policymakers -- all requesting different types of information about AIDS, from details about the disease, to curricula, to model policies dealing with students and staff who are infected. No one who had to answer this volume of mail could doubt that there is a crucial need for information nationwide.

As you are aware, state board members are volunteers. State boards were established under the philosophy that the primary policymakers in education should be lay volunteers. State board members are drawn from a variety of occupations, so that they are in a unique position to advocate for public education. They build consensus among parties seeking to influence state education policy, and act as a bridge between public education, the public, government, political interests, and the business and civic communities.

Among those actors at the state policy level -- governors, legislators, state boards of education, and chief state school officers -- state boards are best placed to address the barriers to providing effective AIDS prevention education.

State boards of education have the authority to oversee elementary and secondary education; they make the policies, rules, and regulations that guide state programs. We establish certification standards for teachers and administrators, set high school graduation requirements, define performance standards for students and schools, adopt textbooks, review and approve the education budget, and develop the standards for a variety of state education

programs. State board members are responsible for the education of about forty million students nationwide -- and, in addition, must struggle with issues such as AIDS education from time to time.

NASBE has received $154,000 cooperative agreement this year from the Centers for Disease Control to aid in their five-year effort to promote effective AIDS prevention education and more comprehensive health education nationwide. The Association's objectives are to help states develop or strengthen policies to prevent the spread of AIDS. The project has two parts. First, NASBE will develop and distribute a Policymaker's Guide to Effective AIDS Education later this spring. It will include model state policies and procedures for promoting effective AIDS prevention education, discussing a range of issues from age appropriate instruction to the needs of youth who are at high risk of infection.

Second, NASBE will give direct technical assistance to policymakers in seven states this year. The purpose is to strengthen the capacity of policymakers and to serve as a support for their efforts. NASBE offers a range of services to state policymakers that include:

- providing basic information about AIDS and effective state plans to different groups of state policymakers,

- facilitating meetings between key players to discuss options for action and the need for fiscal support,

- helping develop interagency agreements,
- helping plan public hearings, or
- helping design a policy development process.

In December, as part of its CDC-funded project, NASBE conducted a state-by-state survey of actions to promote AIDS education. It found that states are moving quickly. Eighteen states now require AIDS instruction, and this number has more than tripled since June of last year. Mandates for AIDS education exist in: Alabama, Delaware, the District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Maryland, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, and Virginia.

States have approached their mandates in different ways. AIDS education has been required as part of comprehensive health education, as part of instruction about sexually transmitted diseases, as part of sex education, as a communicable disease, and by itself. Several states -- including Indiana, Maryland, and Kansas -- have linked AIDS prevention activities with teen pregnancy prevention programs.

All states that mandate AIDS education allow parents to exempt their children from the instruction. Most states require parents to provide a written request to exempt the child, though in Nevada and Louisiana, parents must supply written permission for their child to attend. In New York, a parent who wishes to remove a child from such classes must assure that

similar instruction will be provided at home.

Other state policies require community education and involvement in school AIDS prevention programs. Some encourage parent education. Some specify the grade levels at which instruction must occur -- and seven states require that AIDS education be provided to elementary students. Seventeen states have developed instructional materials or guidelines. Alabama is the only state with a mandatory statewide AIDS curriculum.

Some states are very active although AIDS education is not required. Minnesota has a comprehensive 5-point state plan that combines resources, workshops for school teams, community education, and monitoring. The Department of Education in Maine is helping schools integrate AIDS education into a relatively recent mandate for comprehensive health education K - 12. States such as Oregon, Massachusetts, Michigan, and others have been actively involved in planning and carrying out AIDS prevention education.

A few states have already formed comprehensive plans to provide AIDS instruction and have committed funds to the effort. But a number of gaps remain. Few states have provided funds to departments of education for their AIDS education efforts. Many states do not have comprehensive plans. Few states have addressed the problem of educating youth who are at high risk of infection, many of whom are not in school. Few states have plans for evaluating and monitoring the AIDS education in local schools.

Because we are experiencing a health emergency, it is particularly essential

that states respond quickly and powerfully. Yet it is a formidable challenge to design policies that will address barriers to providing effective AIDS education, including:

- public misconceptions regarding AIDS. A 1987 survey of California school principals in 47 districts showed that most could not correctly answer more than 7 of 14 factual questions about AIDS.

- the rapidly evolving knowledge base about AIDS and its transmission,

- the lack of consensus regarding what should be taught at what grade levels,

- the lack of qualified teachers to provide effective AIDS education,

- local education agency reticence to require effective AIDS education in light of controversy surrounding sex education, and

- the difficulty for state level policymakers to have an impact on classroom level activities. Research shows that state policies that are not thoughtfully constructed either have little impact on what happens in schools or do not accomplish what they were intended to accomplish.

This year, many states will consider whether to require AIDS education. Some proposals will be made in an atmosphere of fear and urgency, and we are concerned that state policies be comprehensive, not reactionary.

In November of 1987, the Kansas State Board of Education required schools to provide AIDS education, and we have a comprehensive plan for providing it. This effort was initiated in the fall of 1986 during a conference on teenage pregnancy. Teen pregnancy has increased in Kansas over the past ten years, despite our efforts to decrease it. This is a major issue in Kansas.

Despite our state's history of strong local control, almost everyone at the conference agreed that sex education should be required in our state. After studying the issue, our State Board voted, in May of 1987, to preliminarily approve a mandate for both sex and AIDS prevention education. Then we held a series of public hearings.

Kansas is a very rural state, though we do have big cities with big-city problems. Before the State Board acted, few districts were offering education about how to prevent AIDS. Local school boards were not offering AIDS education because of local pressure opposing it. For that reason, they were in favor of a state requirement that education about AIDS be provided. I don't think that local districts would be teaching about AIDS now without strong state leadership on the issue.

I should tell you that there was strong opposition to the mandate at the beginning. Prior to the May vote, State Board members were receiving about

100 letters a day, most of them opposed to mandatory sex or AIDS education. We launched a public information campaign that stressed that we were not promoting "safe sex", but were promoting the education of school children about an incurable fatal disease. And it worked. From May to November of 1987, the letters changed. By the summer, the majority praised our action. Letters of support poured in from parents, teachers, and the general public, and they all agreed that it was essential that Kansas children understand how to take responsibility for their own health and to be confident enough to resist the behaviors that would put them at risk of an AIDS infection. Let me read part of one letter to you now:

"Dear Mrs. Hubbell,

As a high school counselor in a small school, I fully support the Kansas State Board of Education in its mandate for AIDS education in all accredited schools in Kansas. The young people in our school have a lack of understanding and an embarrassment that keeps them from seeking the help they so desperately need in coming to grips with the AIDS issue. Properly trained teachers are the best source of a comprehensive AIDS education program -- to not only dispel fears about the deadly disease AIDS, but also to instill responsible decision-making in today's youth.

I fully support your effort on the behalf of the welfare of all Kansans. Please continue your efforts."

In October of 1987, our Board held a final public hearing about the AIDS prevention education mandate. Forty people testified, and more than three-quarters of their comments were very positive. As a result, the State Board voted in November, almost unanimously, to formally change Kansas' rules and regulations to require both sex and AIDS education.

Under our requirement, local schools have the option what to teach, who will teach it, and how it will be taught. This is a community decision. We have encouraged all districts to educate parents. Our mandate requires that teacher training be provided, that standards be set for elementary and secondary teacher training by June of 1988, and that teachers be required to meet these standards after they have been set. The Kansas Department of Education has issued preliminary guidelines for developing and strengthening programs.

Our conservative midwestern state doesn't have the AIDS cases that states with large urban areas have. Only one Kansas student has died of AIDS. The fact that we did mandate sex and AIDS education should show the American people how important this issue is. In Kansas, we saw the need and took action before we had an epidemic in our state. We mandated AIDS education because Kansans are convinced that there is no other way to stop this terrible disease.

We want our AIDS education program to calm student's fears. We want our students to feel good about themselves. Our goal is to promote abstinence and fidelity -- to give children the confidence to say no to illegal drugs

and premarital sex. This is why we encourage a comprehensive program for all grades. In the early grades, children will get information about their bodies, their families, and their lives, to give them confidence, so that they will not engage in destructive behavior later. We want to address other health issues like teen suicide and teen pregnancy -- as well as to prevent AIDS.

This is why I believe that AIDS education belongs in a broader context of more comprehensive health education. We need effective AIDS education immediately for our students, but if we want our programs to have a substantial, long-term impact on our children's health, they must be well-planned and monitored, and be included within a broad range of health-related topics.

AIDS education does not need to be taught as sex education. It can be taught as a communicable disease or in a science class. It can be taught by a minister at a church school. We need to involve parents and the community in both planning and supporting school AIDS education activities. Parents must reinforce the message at home. Churches and other youth organizations can also assist schools in reinforcing the message. Schools should take the lead and involve youth-serving agencies to assist with their work.

Our State Board policy states that it does not endorse the teaching of birth control methods or the establishment of school-based clinics. This is a local decision. It will finally be up to local communities to determine what they will teach their kids. What we are trying to do is to help

educate those people so that they can make informed decisions.

The National Association of State Boards of Education and the Centers for Disease Control are involved in a long-term effort to build the capacity of state and local agencies to educate everyone about AIDS and the need to improve school health programs. This is a good example of how education and health agencies must work together -- at the national, state, and local level -- to support better health programs in the schools.

As AIDS prevention education policies are formulated nationwide, policymakers will face some tough questions. For example, should AIDS prevention education be required, as in Kansas? States will answer this question in different ways according to their needs. In addition, mandates without funding and comprehensive plans for teacher training, materials, and community education are not meaningful mandates.

Let me list a few of the points that NASBE will stress as it provides technical assistance this year. In each state, we will stress the need for better health programs for all students. If students don't understand about germs and the immune system, they will not understand what an HIV infection is and how to avoid it. We need more than just another fragmented policy initiative or one more requirement in health education.

But if schools don't already have a comprehensive health program, they can't afford to wait until a new curriculum has been developed and implemented. Young people need information about AIDS now.

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We will also stress the importance to promoting effective AIDS education programs -- programs that don't stop with providing information, but are designed to affect the attitudes and behavior of students. Psycho-social prevention models that have produced significant reductions in the onset of smoking can be used to help children resist peer pressure. Peer counseling needs to be more fully explored. But most importantly, schools can't provide effective education alone. Schools must reach out to parents, youth-serving organizations, and churches for help in reinforcing the message students get at school. Many program managers speak not of community opposition to AIDS education, but of apathy about education in general.

I know that I don't need convince you how important AIDS prevention education and comprehensive health education are. But I want to stress how important state leadership can be in fighting this epidemic. In Kansas, Governor Hayden was 100 percent behind State Board efforts to provide AIDS education. Over 80 percent of our citizens support AIDS education in high school. Our Governor is proposing a 1.5 million dollar appropriation for our program -- spending $3.75 per student.

But much remains to be done. Many states have not taken leadership and made comprehensive plans to stem the AIDS epidemic. Policies may be enacted in an atmosphere of haste and fear. Perhaps some policymakers think that AIDS will never be a serious problem in their state. But 1 in every 7 teenagers gets a sexually transmitted disease each year, and all of these youngsters

are at risk of an AIDS infection. We cannot take this chance with our children's lives. Education is our only tool.

I would like to express my sincere appreciation for having the opportunity to talk with you this morning. NASBE and its state board members stand ready to work with you in confronting a national health crisis.

Mr. OWENS. Thank you, Ms. Hubbell.

We are going to have to take a 10-minute recess to vote. We will return in 10 minutes.

[Recess]

Mr. OWENS. The committee will please come to order.

The next witness is Ms. Abelson for the New York City Board of Education.

Ms. ABELSON. Thank you, Mr. Chairman, and members of the committee, for inviting the New York City Board of Education to speak at this hearing.

New York City, as you know, has had a major crisis in AIDS, drugs, sex, and every other crisis that has come before the public and/or youth alike.

While many people throughout the country, including our State Department in Albany, think we represent a very liberal community. The reality is we represent a very heterogeneous community with both extremes within most of our localities. What that means is that we have a problem in AIDS and with AIDS, as well as other topics, with adolescents dying of AIDS already.

As was noted earlier, with the incubation period and the rate of infection and identified AIDS cases, and the ages of 20 to 29 we know that AIDS is an epidemic amongst our adolescents right now.

I know you are on top of it—heard the latest statistics about two weeks ago of one in every 63 babies born in New York City have HIV antibodies at birth. Forty percent of our adolescents in New York City are sexually active. One in five become pregnant. A few more numbers just before I move on to some of the programs in terms of the city.

We have 10,000 to 20,000 new IV drug users under the age of 20 every year. We have 8 to 10 percent homosexuals and lesbian youth; 38 percent of the school population is black, and 34 percent Hispanic—these groups with infection rates greater than their incidence in the population. So we have communities that are particularly at high risk as well as the general population who are at risk.

What we have been doing in the past two years since the chancellor's mandate in the Spring of 1986 is working on a zero budget with a mandate for AIDS education in the high school and a charge for AIDS education at the district level.

We began in the Fall of 1985, actually, after the initial court case that was heard with one of our districts against the Board of Education in reference to allowing a child with AIDS in school. As a result of the hysteria in the media that came with that court case, the chancellor convened a task force that made recommendations to develop educational materials for all Board of Education personnel, and a video that would be used in the middle and senior high school level.

We had no budget except for that video. We began working with the Department of Health and the Gay Men's Health Center in terms of getting materials, gathering resources, and starting to begin a program.

We have, as Chairman Owens is aware, a million students and more in the schools, we have 100,000 school personnel. Developing a program within New York City is like trying to develop a program statewide. We are very sensitive to the need for community

input, parental input, as noted earlier by Mr. Grandy. We have long had that type of input in the way of advisory committees with our family living sex curriculum which we have had for many years and which was mandated this past October.

It has been a very effective tool. We work with parents. We work with community groups. We have made a joint team effort that has worked to help our youngsters and introduce curriculum that was sensitive in the past.

One of the issues becomes the reality of going through all of these wonderful processes and actual implementation. So what happens is we have a State-mandated comprehensive health program, and as of a month ago we have a State-mandated K through 12 AIDS guideline that gets introduced into that comprehensive program. However, that works wonderfully for K through 6.

What happens is you have two semesters—one semester two times a week, one semester three times a week, of youngster in the middle school—usually the seventh grade, maybe the eighth grade—getting help—and you have one semester in the high school, usually in the eleventh grade after 50 percent of our youth drop out of school.

So when students are most active in the behaviors that could put them at risk or most endangered of getting involved in those behaviors that might put them at risk, they do not have comprehensive health.

So that we have a pull in two directions, so to speak. We have the understanding of the importance of comprehensive health. You need to integrate the skills that come out of comprehensive health—the self-esteem issue, the decision-making issues, they respect in the community issues that come out of these kind of programs and we recognize the importance of that. And yet we have a health crisis in New York and we don't want to wait until another child dies, which is what it comes down to.

So that we have to integrate—and what we are working on now is integrating AIDS into the general health curriculum, the growing healthy curriculum, the teen-age health teaching modules, the high school curriculum, and developing a separate AIDS curricula that will reach the students who are not in those comprehensive programs at the time.

We have long since been arguing to get health education in a lower grade in the high school level. We have long since identified the need to have comprehensive health more than once in full semester, in high school level as well as the middle school level.

One of the problems comes with not having health recognized as an area that does indeed help our youngsters learn and adjust better in school and succeed more readily in math, science, physics, et cetera.

There have been enough studies done that show that the self-esteem levels that start off that may be 80 percent in the lower grades of elementary school and lined up, if we are lucky, being 20 percent as kids graduate high school. We do know that self-esteem is one of those underlying issues that help youngsters reduce risk behaviors, whether it has to do with cigarette smoking, or sexuality, or drugs.

So what I am trying to say is that the policy and the theory all works very well and is very important. The realities of implementing that program are a different picture.

Additionally, as I said, we have been working with advisory committees and parents' groups for several years in sex education so we have a very good reputation at this point with our communities. However, there are still issues.

I was in Mr. Owens' community giving a panel community thing just the other day. I checked my statistics for who out of those two school districts came to AIDS training in the earlier part of the year, and there were 12 people in the two school districts.

Now, that has nothing to do with the State Board policy, city board policy. It has to do with an ongoing denial of the need for this type of education and its place within the school system. When youngsters take band practice instead of getting health in the fifth grade, when people are saying, well, we have too much to do and we can't do this, we are talking about an attitudinal issue that reflects a broad range of the community at large; a community that's saying, not my community; a community that is saying, if we just teach abstinence and say no, that's all that it takes; a community that is overwhelmed by the problems and doesn't know where to begin.

So the actual reality of this implementation and the use of local input into developing it often creates a gap between the identified need for the program, a charge to do the program, and youngsters actually getting what they need so that they can live through this experience.

The more and more I talk to parents, the more and more they are responsive—they are scared, they are very involved, they are very interested, but they have several issues. One of the major issues we have in New York City is the position of the religious groups in the community, the position of the gay groups in the community, all of whom, and many of whom in this community are representative on our city-wide advisory committee as well as our district-wide advisory committees.

What happens is while everybody is sitting and arguing—and this was mentioned earlier—what is explicit, what isn't; what is preventive, what isn't—it's not in the classrooms, and this is a major concern. Chairman Owens mentioned that earlier, with the whole debate and the intellectualization of this issue.

What we have to come to terms with—and we have it consistently with what I call simplistic responses—and our video is AIDS: just say no—so we have obviously joined the bandwagon to some degree. But there are skills involved in respecting community and family values. There are skills involved in just saying no. There are skills involved in communicating around this issue, and those skills—and dealing with the skills that enable youngsters to address these issues often get into area of greater explicitness. You can say just say no to sex and drugs but then what that means in terms of when Johnny says this or Mary says this, we can't quite keep it—a term some members of my advisory committee use—hygienic, as some people would like.

I think additionally the concern and in reality the politics of community-based districts and the constituencies in the special in-

terest groups in that leave curriculum areas in much debate. I am hoping that the mandate, the K through 12 mandate as of 1988 from the SED in New York, will help facilitate that. But when you have a city like New York City, sometimes being held accountable is not as easily done as said.

So that is one whole chunk in terms of the reality—the implementation.

A good example, I guess, is what happened with the video. We were charged with developing a video for the middle and high schools in September of 1985. It wasn't until the spring of the following year—a year and a half later—that a video actually got before any students. That, again, was with the concerns of the religious and the conservative groups, and what was said, and how much abstinence was stressed. It was certainly not a perfect video, and I don't know anybody that has had the opportunity to develop such an article that would meet the needs of every community.

But, again, the need for teacher training in terms of implementing any curricula or educational material becomes a major force. When we look at that we are looking at 100,000 people. We are looking at over 60,000 classroom people, and over 40,000 support personnel. We train close to 1500 the first two years without any funding and we are hoping to train over 5,000 this year. And that still becomes a drop in bucket, because when you are dealing with our urban youth and you are dealing with a school system the size of New York, everybody has to participate.

We have to do, and we are contracted with CDC—and I have to take this opportunity to thank CDC for funding us and allowing us the opportunity to expand our program. We have to reach parents. We have to reach teachers. We have to reach every support member. We have to reach community boards, and we have to reach the public. It has to be a joint effort. Communities have to work with the school systems: community organizations, parents.

We have to have an effort that goes from the community into the schools and from the schools out to the community if we are going to really reach our youngsters at a massive level. We can't rely on the turnkey training we have been relying on. We can't rely on not having enough staff to go out to the districts to give them the technical assistance and support they need to talk to the groups and their constituencies with some expertise. It takes a great deal of staff.

Our CDC grant comes down to 30 cents a child. With monies we are getting shortly from the State Department of Health and the State Department of Education it will come to 60 cents a child. It just isn't enough, quite honestly.

We don't have a city budget yet. We submitted a proposed budget and we don't know what is happening with that yet but we have had no city board of education commitments yet for money.

We have, as you know, a high dropout rate. One of the things we are doing with our commitment to CDC is working with all the settlement houses in the city as an umbrella organization that has a track record of trust and communication with the community; working with high-risk populations—and by that I say youngsters that are involved with drugs, youngsters that have dropped out or in youth employment programs; youngsters who are at the fringe

of not quite dropping out and not quite being there yet. We will be training all of their youth teams and putting on workshops in their community to get them all started in this joint effort.

We need to build trust amongst both community and parent groups that the Board of Education is indeed there to meet the needs of their population. We need the support in time to recognize the multiple problems we are having in terms of staffing and funding and reaching out to those thousands of people—but we can't do all at once—which brings me to just a final point in reference to that.

We have not targeted special populations in New York. I think it is a thin line that the Board sits on between being called biased and racist in identifying groups and biased and racist in not identifying groups. But one of the realities is, is that every adolescent in our city is at risk. Some adolescents are certainly at greater risk.

The one thing we are trying to do is work within those communities, both with the settlement house programs in some of those communities and with the community-based programs to increase awareness and give support and make sure the programs that we have in existence do get expanded and do get enlarged.

But we are trying to reach every school, every parent group in the school; create parent leaders so that we have peer parent level groups going out and talking to more parents, so there is trust on that same level; creating staff within the districts who feel that they are capable of at least serving as a liaison between Central Board and the classroom teacher.

Many of us are overworked, so that you have somebody who is responsible for pupil personnel and this program and that program, and then we say, and now we would like you to take on AIDS too. At this point I am the only person at the New York City Board of Education having any major responsibility for this. Staff has not come on because of the red tape involved in bringing any staff on—and it is just a beginning. At each point, I think people need to be aware that developing programs—there is a process, unless—I mean, you can't reach all your community groups or your parents groups, or your teachers, and get the kind of support that you need to implement a really successful program overnight. It takes time, it takes process. We learn day by day what is needed. We learn to work differently every day.

The curriculum that we are working on now does not look anything like the curriculum that was so innovative two years ago—and that that kind of time is needed, but the support both financially and psychologically is needed.

Just one last thing.

Mr. OWENS. Can you wind it up and we will allow you to elaborate in the question period on some of the questions.

Ms. ABELSON. I just wanted to add that one of the last issues that are tying our hands is the new Helms amendment, because we have used gay materials. We do have gay constituency on our advisory committee, and when there are recommendations from the local advisory committees to do some self-acknowledgement around homosexual youth in our schools, it is another thing that ties the hands of our committees in making the curriculum go from committee into the classroom.

Thank you for allowing me to share this with you.

[The prepared statement of the New York City Board of Education follows:]

New York City
Board of Education

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Chancellor

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AIDS EDUCATION-NEW NEEDS

NEED:

The prevention of the spread of AIDS continues to be the primary public health concern in our nation. The New York City Board of Education plays a major role in prevention efforts. Reaching youth before they become sexually active and involved in drug use will help us stem the spread of this disease. Additionally, education of youth who are possibly involved in high risk behaviors is urgent. The Centers for Disease Control's $300,000 grant has enabled the Board of Education to begin expanding its AIDS education efforts. However, more needs to be done.

In the 1987-1988 academic year, staff development for selected Health and Physical Education teachers and supervisors, school based support teams, special education trainers and supervisors, and central board and community board staff will be completed. However, training planned for future years, i.e. for science and social studies teachers, should ideally begin now. Additionally, innovative programs need be developed in order maximize preventive education efforts.

DESIGN:

In order to accelerate staff development and assist the districts and high schools in the implementation of AIDS education, four additonal staff members are needed, one for each borough. This would permit the Office of Health, Physical Education and School Sports to provide ongoing technical assistance and additional school-based staff development.

Since peer programs have been shown to be effective in helping adolescents change behavior, a peer education project would be developed in each high school. One teacher in each school would be assigned to supervise the program. The teachers would be given four days of training and ongoing technical assistance. The students would be trained and given a stipend for their work.

BUDGET

4 Training Development Specialists @ $32,600	$ 130,400
Fringe Benefits (25%)	32,600
120 Peer Teacher Advisors x .2 x $43,142	1,035,408
Fringe Benefits (40%)	414,144
Peer Advisor Training 40 x 6H x $10 x 120	28,800
4 Trainers x 30H x $23.45	2,814
Fringe Benefits (8.39%)	2,652
Student Stipends 12H x $3.50 x 120 x 3 students	15,120
150 Training Packets	5,000
Afterschool Staff Development 7,500 tchrs. x 6H x $1C	450,000
Training Materials	10,000
Secretary	19,292
Fringe Benefits (25%)	4,823
Temporary Office Assistance	5,000
Office Supplies	5,000
Postage	2,000
Travel (local and out of town)	5,000
TOTAL	$ 2,168,053

New York City
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THE DEVELOPMENT OF AIDS EDUCATION IN THE
NEW YORK CITY PUBLIC SCHOOLS
September 1985 - June 1987

CURRICULUM AND EDUCATIONAL MATERIALS DEVELOPMENT
STAFF DEVELOPMENT
CLASSROOM IMPLEMENTATION

September 1985

The Department of Health in cooperation with the Office of Media and Telecommunications of the Division of Curriculum and Instruction began development of a video tape for AIDS education. In this tape, AIDS: Acquired Immune Deficiency Syndrome, the Chancellor and medical experts addressed the AIDS crisis and provided current social and medical data on the disease.

The Division of Curriculum and Instruction, Office of Health, Physical Education and School Sports began developing a junior high school and senior high school curriculum on AIDS to be issued as a supplement to the Family Living Including Sex Education curriculum..

October 1985

A comprehensive package of AIDS information was distributed to all school personnel by the Department of Health. Materials were timed to coincide with the showing of the tape.

Students were released from school at noon on October 28th, to allow all school personnel to view and discuss the tape as it broadcast on Channel 13 and Channel 25.

December 1985

AIDS information was integrated into the School Program to Educate and Control Drug Abuse (SPECDA) curriculum. (The SPECDA effort is a collaborative program between the Board of Education and the New York City Police Department.)

Approval was given by the Department of Health and Board of Education for the AIDS curriculum, consisting of two lessons each for the junior and senior high schools. These materials emphasized the basic facts about AIDS, high risk groups, methods of prevention and civil rights issues for people with AIDS.

January 1986

Staff development about AIDS and the implementation of the curriculum was conducted for high school teachers, guidance counselors, and health resource coordinators. Subject areas represented included: health and physical education, science, home economics and Family Living Including Sex Education.

Five half-day sessions were held one in each borough. Sessions were conducted cooperatively by the Division of Curriculum and Instruction and the New York City Department of Health and involved approximately 1,350 high school personnel.

February 1986

A follow-up citywide staff development session was held to accommodate any personnel who were unable to attend the January sessions.

March 1986

AIDS education was mandated for all high schools. Many high schools conducted parent workshops and all students grades 9-12 were taught a minimum of two lessons focused on AIDS.

April 1986

A six hour session was held in each of four regional sites to provide professional development for all school-based personnel involved in drug prevention and counseling. These sessions focused on AIDS information and counseling issues. Approximately 220 drug counselors and supervisors participated.

November 1986

Staff development about AIDS and the implementation of the curriculum was conducted for intermediate/junior high school teachers, guidance counselors, and health resource coordinators. Subject areas represented included: health and physical education, science, home economics and Family Living Including Sex Education.

One full day professional development session was offered at four regional sites and approximately 150 district office staff and school-based personnel were involved.

Classroom instruction began in some community school districts.

January 1987

Two lesson plans and related materials were prepared to accompany ODN video tape, "Sex, Drugs, and AIDS."

February 1987

The lessons and tape were piloted at a demonstration for 35 selected high school seniors from 15 schools. Their comments were included in the revision of the lessons.

April 1987

A two-hour staff development session at each of four regional sites was held to prepare high school personnel to use the video "Sex, Drugs and AIDS." Approximately 325 staff members participated.

Each high school was given a copy of the video and the accompanying lessons.

June, 1987

High school seniors throughout the city viewed the tape and participated in the lessons

A revised video, "AIDS, Just Say No" was produced for dissemination to all secondary schools for the Fall of 1987.

NEW YORK CITY BOARD OF EDUCATION AIDS PROJECT

ABSTRACT

The New York City Board of Education AIDS Project will conduct a variety of activities to increase the number of students receiving effective AIDS education in grades 5-12.

The number of schools and professionals providing effective AIDS education to inschool and out-of-school youth will be increased through the following activities.

- Establishment of one Citywide and five Boroughwide AIDS Project Advisory Committees that will draw on health professionals and community representatives to advise on program development and to review materials that are developed or purchased.
- Training of 74 parent trainers and conducting of 292 parent workshops reaching approximately 5,000 parents.
- Presentation of three to six hours of staff training for 4,620 central Board, community school district, and building staff members.
- Training of 100 youth and other outreach staff of the United Neighborhood Houses to provided required services to out-of-school youth.
- Workshops for approximately 480 United Neighborhood Houses youth clients.
- Establishment of an Board of Education AIDS Resource and Instructional Materials Center.

The number of schools that integrate AIDS education into a more comprehensive school health program will be increased through the following activities:

- Development of lessons for the "AIDS; Just Say "No," video, for four health curriculums used in New York City, and for the junior and senior high school science curriculums to (1) integrate information on AIDS into existing lessons for relevant concepts such as infectious diseases and (2) develop discrete lessons on AIDS consistent with each curriculum's format.

Students' levels of AIDS-related knowledge and the availability of baseline data will be increased through the following activities:

- Implementation of a staff needs assessment to determine needs for staff development training.
- Collection of baseline data on school-aged youth's knowledge about AIDS, attitudes toward AIDS and risk-reduction behaviors, and AIDS-related behavioral intentions.
- Determination of changes in knowledge, attitudes, and behavioral intent of students whose teachers receive staff training.
- Observation of the extent to which trained teachers implement AIDS instruction.

NEW YORK CITY BOARD OF EDUCATION AIDS PROJECT

1. Objective #1.0: Increase the Number of Schools that Provide Effective AIDS Education in Elementary, Junior High and Senior High Schools and the Number of Professionals Who Provide Effective AIDS Education to Out-of-School Youth

a. AIDS Project Advisory Committees #1.1

2) Subobjective #1.1

By the conclusion of the advisory committee period from August 3, 1987 (prior to the project start date of October 1, 1987) to June 30, 1988, one Citywide and five Boroughwide AIDS Project Advisory Committees will advise the project director on program development, assist in mediating educational barriers, and review curriculum materials. This will result from regularly scheduled committee meetings held at sites citywide and will be shown by rosters of committee membership and minutes of committee meetings.

b. Parent Training #1.2

2) Subobjective #1.2

By the end of the parent workshop period from October 1, 1987 to June 26, 1988, 4,985 parents of in-school and out-of-school youth will participate in three to six hours of workshop activities on AIDS. This will result from training sessions conducted by NYCBOE specialists and project-trained parent workshop facilitators and will be measured by a locally developed post-session reaction form.

c. Training for New York City Board of Education Staff #1.3

2) Subobjective #1.3

By the conclusion of the New York City Board of Education staff training period from July 13, 1987 (prior to the initiation of the cooperative agreement) to May 27, 1988, 4,620 members of the NYCBOE staff will participate in three or more hours of training designed to meet their professional needs. This will result from training activities appropriate to each group and will be measured by a locally developed post-session reaction form.

d. Training for United Neighborhood Houses Staff Working with Out-of-School Youth and for Out-of School Youth #1.4

2) Subobjective #1.4

By the conclusion of the UNH staff and youth training period from December 1, 1987 to April 29, 1988, 100 UNH youth and related staff and 480 youth will participate in six hours of training. This will result from 36 workshops conducted by the project director and the project coordinator and will be measured by locally-developed post-session reaction forms.

e. Establishing an AIDS Resource and Instructional Materials Center #1.5

2) Subobjective #1.5

By the end of the AIDS resource center creation period from December 1, 1987 to May 31, 1988, the project coordinator will establish an AIDS resource center. This will result from selection of an accessible site and expansion of the existing collection of resource materials and will be measured by the availability of the resource library for use by staff.

2. Objective #2.0: Increase the Number of Schools that Integrate AIDS Education Within a More Comprehensive School Health Program that Establishes a Foundation for Understanding the Relationships Between Personal Behaviors and Health

2) Subobjective #2.1

By the conclusion of the health education curriculum development period from July 13, 1987 to August 31, 1988, health education curriculum writers will expand four existing health and AIDS education curriculums and the junior high/intermediate school and high school science curriculums by identifying age-appropriate scope and sequences for each curriculum and developing detailed lesson plans consistent with each curriculum's format. This will result from a critical review of the AIDS-education literature, technical assistance from local and state DOH's and CDC, and review by the AIDS Curriculum Advisory Committee. It will be measured by availability of the curriculum materials for review, use, and dissemination.

3. Objective #3.0: Increase the Level of AIDS-Related Knowledge and/or the Availability of Baseline Levels of AIDS-Related Knowledge Among Students in Schools and Out of School

a. NYCBOE Staff Needs Assessment #3.1

2) Subobjective #3.1

By the conclusion of the staff needs assessment period from September 1, 1987 to November 30, 1987, the Office of Educational Assessment will determine the AIDS-related education needs of randomly selected instructional, building-level, and central Board staff. This will result from administration of a locally developed survey instrument.

b. Student Baseline Data #3.2

2) Subobjective #3.2

By the conclusion of the baseline data collection period from October 1, 1987 to December 18, 1987, the Office of Educational Assessment will collect baseline data on in-school youth's (1) knowledge about AIDS, (2) attitudes toward AIDS and risk reduction behaviors, and (3) behavioral intentions. This will result from administration of a locally developed survey instrument.

c. Increasing the Number of Students Receiving Effective Aids Education Integrated Into an Existing Health Curriculum #3.3

2) Subobjective #3.3

By the end of the student training period from February 1, 1988 to June 17, 1988, 90% of students 5-12 whose teachers received training through this project will receive one or more AIDS lessons integrated into the ongoing health education curriculum. This will result from teacher training activities and availability of age-appropriate lesson plans on AIDS for each health curriculum and will be measured by a locally developed survey instrument and site visits to randomly selected classrooms (with teacher approval) to observe program implementation.

d. Increasing Students' Knowledge about AIDS, Changing Attitudes Toward AIDS, and Changing Behavioral Intent #3.4

2) Subobjective #3.4

By the end of the student training period from February 1, 1988 to June 17, 1988, NYCBOE students 5-12 who have received one or more lessons on AIDS will significantly increase their knowledge about AIDS, develop more positive attitudes toward risk reduction, and develop positive intentions to reduce high behaviors. This will result from one or more lessons on AIDS and will be measured by a locally developed reaction form.

SAMPLE LESSON PLANS FROM

AIDS Curriculum 1987

WORKING DRAFT

New York City Board of Education
Division of Curriculum and Instruction • Office of Curriculum Development and Support

LESSON 1 — All Secondary Grades

AIM: How can we protect ourselves from AIDS?

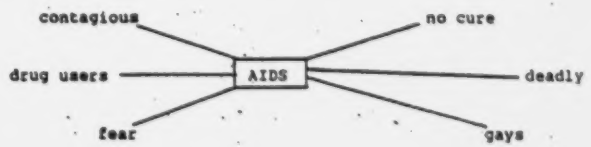
PERFORMANCE OBJECTIVES: Students will be able to:

- identify the facts related to AIDS.
- explain how AIDS is changing the decision-making process related to sexual intercourse.
- describe the relationship between drug use and AIDS.
- analyze how prejudice can change.
- explain how saying no to drugs and sex assures the prevention of AIDS.

SPRINGBOARD:

- When you hear the word AIDS, what are some words or phrases that come to mind?

- Write students' responses on the chalkboard in a web of words, for example:



- Ask students to select two or more of the response words. Have them write a question about AIDS related to the words.

DEVELOPMENT:

- Tell the class they will now see a film about AIDS that may answer some of their questions.

- To guide their viewing, ask the class to find the answers to the following general questions as they watch the film.

  - Why is AIDS "hard to catch"?

  - How is AIDS related to drug use?

  - How does saying "no" to drugs prevent AIDS?

  - How is AIDS affecting people's decisions about sexual intercourse?

  - How does saying "no" to sex prevent AIDS?

  - Why does the bicycle shop owner change his attitude toward homosexuals?

- After the film, discuss the viewing questions. Ask additional probe questions, such as those listed below, to guide the discussion.

  - How is AIDS transmitted?

  - Based on the film, what message would you give to drug users? What message would you give to someone making a decision about sexual intercourse? Why is it sometimes hard to "just say 'no'"?

  - How can you help someone to say "no"?

- Ask students to write an answer to the questions they composed at the beginning of the lesson. Call on volunteers to read their questions and answers.

HOMEWORK:

- Have students discuss the film with family members. Tell them to be prepared to talk about the issues and feelings expressed in their home discussions.

LESSON 2 — All Secondary Grades

AIM: How can we deal with the fears about AIDS?

PERFORMANCE OBJECTIVES: Students will be able to:

- recognize that ignorance produces fear.
- explain why individual responsibility is important in reducing fear.

SPRINGBOARD:

- Were any feelings of fear expressed by your family members during your discussion at home? If yes, what were they about?

DEVELOPMENT:

- Write some of these fears on the chalkboard.

  - What would a person have to know to reduce some of the fears we have listed?

- Distribute the Activity Sheet, "I'm Afraid of_____." Ask each student to complete the activity sheet, following the directions. Then divide the class into small groups.

- Instruct the groups to discuss the reasons for any similarities or differences in the responses among individual group members. (Allow about ten minutes for this activity.)

- Ask different groups to report on their responses to different fears.

- Distribute the following Fact Sheet, "Turn in Your Fear for Facts." Review the information most pertinent to the students' concerns.

HOMEWORK:

- Direct students to use the Fact Sheet to answer the various concerns raised by their families.

ACTIVITY SHEET

All Secondary Grades

I'M AFRAID OF _____.

Directions: Read the list below and choose the three strongest fears you have concerning AIDS. Number these from 1 to 3 on the lines provided--with the strongest being 1.

____ getting a blood transfusion.

____ being around my neighbor who is gay.

____ eating in a restaurant, because someone who works there may have AIDS.

____ being bitten by mosquitos.

____ having sex with my boyfriend/ girlfriend.

____ giving blood.

____ being friends with someone who I know has shot up.

____ not knowing if someone in school has AIDS.

____ having AIDS and not knowing it.

____ not having the courage to say "No."

FACT SHEET

All Secondary Grades

TURN IN YOUR FEAR FOR FACTS

Getting a Blood Transfusion

On an ongoing basis, the New York City Department of Health surveillance of AIDS has found that, including hemophiliacs, less than 1% of all reported cases of AIDS resulted from blood transfusions. There is no blood test for AIDS, but in April 1985, a test was developed to show whether or not antibodies to the HIV virus are present in blood. Now all donated blood is tested. Blood which shows the presence of these antibodies is not used for transfusions. Therefore, the 1% includes those who were infected before April of 1985. In the future this percentage is expected to drop even lower.

Being Around My Neighbor Who Is Gay

All gay people do not have AIDS. Anyone who engages in high risk behaviors puts himself/herself at risk for AIDS. Everyone else has nothing to fear from anyone--homosexual or heterosexual--because AIDS is not transmitted by casual contact.

Eating in a Restaurant

You cannot get AIDS from eating in a restaurant where someone with AIDS works. AIDS is transmitted sexually, through sharing IV (intravenous) drug needles, and through blood to blood contact. AIDS cannot be transmitted in food, on dishes, or in cooking or serving.

Being Bitten by Mosquitos

There are no known HIV infections caused by mosquitos. If mosquitos could transmit AIDS, old people, young children, and others with no risk factors would have become infected. This has not happened.

Having Sex With My Boyfriend/Girlfriend

Having sexual intercourse can put you at risk for AIDS if the person you are having sex with is infected. Because the virus can incubate for 6 months to 10 years or more, you may not know if your boyfriend/girlfriend has been infected. Using a condom together with a spermicide (nonoxynol-9) can help reduce your risk of AIDS. However, but condoms have a 10% failure rate.

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FACT SHEET (continued) All Secondary Grades

Giving Blood

Giving blood is completely safe. Clean needles are used each time a person donates blood so there is no risk of transmitting AIDS.

Being Friends With Someone Who Uses Drugs

Being friends with someone who uses drugs will not put you at risk for contracting AIDS. However, people who use drugs often pressure others to join them. It will be hard to keep saying "no" and remain friends. Also, using any kind of drugs, including alcohol, can affect your decision making ability and lead to behavior you would regret.

Not Knowing If Someone in School Has AIDS

Someone in school with AIDS will not put you at risk of becoming infected with AIDS. AIDS cannot be transmitted by casual contact. Children who have been born with the HIV virus have not infected their brothers and sisters or other family members. AIDS has not been passed on by an infected child to any other children, even when an infected child has shared food with other children, has kissed and hugged them, and has used the same toothbrush.

Having AIDS and Not Knowing It

If you think you may have been exposed to AIDS, you can be tested for the HIV antibodies. You can call the AIDS hotline (718) 485-8111 and ask for a Department of Health testing site. All testing is free and confidential. Counseling before and after testing is provided.

Not Having the Courage to Say "No"

It's not always easy to say "no" to a friend or to say "no" when you are being pressured by peers. The best thing is to choose friends who are not involved in high risk behaviors. Also, try to think about situations before you are caught in them.

SAMPLE LESSON Grade 9

AIM: What are the responsibilities of families and communities for people with AIDS?

PERFORMANCE OBJECTIVES: Students will be able to:

- identify how families and friends can help people with AIDS cope with physical, emotional, and economic needs.
- identify needs that can be met only with community assistance.
- research community resources that can offer help to people with AIDS and their families.

SPRINGBOARD:

- Ask students:

  - Who takes care of you when you're sick?

DEVELOPMENT:

- Place the following statement on the chalkboard.

  Friends and families meet many needs for individuals.

- Ask the students to brainstorm what some of these needs are.

  Sample:

  FRIENDS and FAMILY

  companionship
  protection
  advice
  guidance
  emotional support
  love
  financial support

- Divide the class into small groups to list ways friends and families can help people with AIDS meet their needs.

- Ask a person from each group to share their list with the class.

- Ask the following questions:

  - What needs would friends and families often require help in meeting? (emotional and financial needs)

  - What needs would friends and families often be unable to meet? (health care, housing)

SAMPLE LESSON (continued) Grade 9

- Have students list the kinds of resources that would be needed to meet these needs.

HOMEWORK:

- Write on the chalkboard: AIDS hotline (718)485-8111
- Give each group an assignment. One member of each group will call the hotline and ask for information about local facilities in one of the following categories: medical, housing, legal, social service/counseling, education/information. The group is then to call or visit the site to which they are referred, gather further information, and report back to the class.

SAMPLE LESSON 4

Grade 10

AIM: What Role Can Each Person Take in Preventing the Spread of AIDS?

SPRINGBOARD:

- Write on the Chalkboard: "We Can Stop AIDS."
- Ask students to respond to the statement.

DEVELOPMENT:

- Ask questions such as the following:
  - What can you do today to prevent the spread of AIDS?
  - What can you do in your future to prevent the spread of AIDS?
- Ask students to take 3 minutes to list the ways in which they can prevent the spread of AIDS now and in the future.

Sample:

TODAY:

1. Do not use drugs.
2. Do not have intercourse.
3. Don't hang out with people who are going to pressure you to use drugs or have intercourse.

FUTURE:

1. Do not use drugs.
2. When you have intercourse, use a condom and spermacide (nonoxynol 9).
3. Get tested for HIV antibodies before planning a family if you think you or your partner have been exposed to the AIDS virus.

- Have volunteers share some of their responses.
- Divide class into groups of three. Explain that they will now take turns role playing and being observer-reporters.
- You may want to use the situations on the following Activity Sheet, "What Do You Think?" However, to insure that the situations are appropriate for the class, you may have students devise the situations they will roleplay.

SAMPLE LESSON 4 Grade 10

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SAMPLE LESSON Grade 11

AIM: How does HIV infect the body?

PERFORMANCE OBJECTIVES: Students will be able to:

- identify the cells affected by HIV infection.
- explain why HIV infection is "permanent."

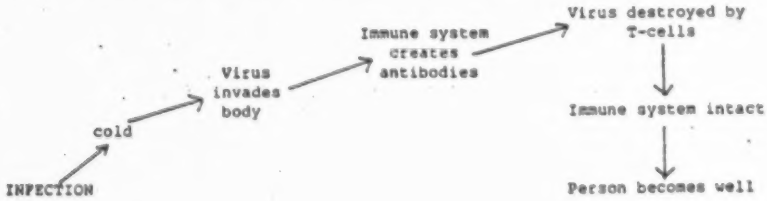
SPRINGBOARD:

- All of us have had some illnesses that affect the body and then disappear. Can you identify some of these illnesses? (possible responses: measles, a cold)

DEVELOPMENT:

- Ask students if anyone knows why HIV infection is permanent?

- Explain how the body normally fights disease. Reproduce the following chart on the chalkboard and label it "The Immune System."



- As you label each step of the process, tell students what the body is doing.

  - "Virus Invades Body." During the first phase of infection, white blood cells attack the invading antigens (antibody generators) at the site of entry. They surround and break them apart. This first attack of white blood cells is followed by a second attack of white blood cells. They surround both the invading organism and the original defending cells, removing them from the site of infection.

  - "Immune System Creates Antibodies." The second phase of infection is when the antigen (antibody generator) triggers the immune system response. The body takes a week or more to fully develop an immune response to an antigen. The immune system response provides the body's second, and very effective, defense against most disease. It is also responsible for lasting protection (immunity) that usually follows some infections.

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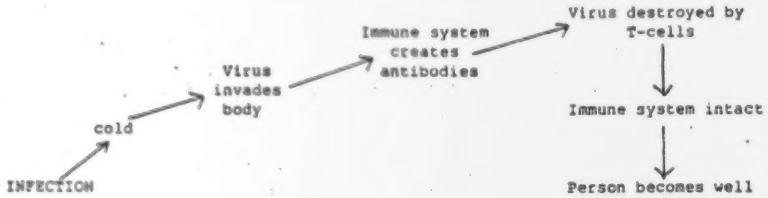

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SAMPLE LESSON Grade 12

AIM: What are some of the civil liberties issues raised by AIDS?

PERFORMANCE OBJECTIVES: Students will be able to:

- summarize some of the civil rights issues involved in administering the screening test.
- explain why the New York City Department of Health finds that the general public would receive no benefit from public identification of people with AIDS or of people exposed to the HIV virus.

SPRINGBOARD:

- Almost every week television and newspapers have a story related to AIDS. For example, the military has decided to test all their personnel to determine who has been exposed to the HIV virus. Do you think the names of people who test positive should be available for public information?

DEVELOPMENT:

- Distribute the following Activity Sheet, "Civil Rights Issues in HIV Antibody Testing."
- Ask students to read the pages to find two reasons why the Department of Health has decided to keep information on HIV virus testing confidential.
- Ask volunteers to read and comment on these two reasons (underlined on first page of activity sheet).
- Divide the class into six groups. Explain that their role is to advise the Mayor on public policy. Assign group leaders who will report the groups' recommendations and their reasons for those recommendations to the class. Two groups should consider question 1; two groups questions 2, 3, and 4; and the other two groups should consider questions 5, 6, and 7.
- Choose one group to report on each of the assigned question groupings. The other groups may make any comments necessary to represent their own findings.

FOLLOW-UP ACTIVITY:

- As a follow-up assignment, ask students to write a letter of advice to a person who is afraid of contracting AIDS because he/she thinks someone he or she works with might have it.

SAMPLE LESSON (continued) Grade 11

- "Immune system breaks down." The immune cells that are attacked by HIV are the T-helper cells. When the virus reproduces in the T-helper cells, these cells lose their ability to fight disease. Eventually so many T-helper cells are lost that immune deficiency results. As a result of loss of T-cells, the B-cells are no longer stimulated to produce antibodies. Once this process of change has begun, the immune system can never return to its full capacity to fight disease.

- "Person becomes ill and susceptible to many kinds of infections." The loss of immunity due to HIV infection is selective and primarily affects the parts of the immune system involved in defense against certain parasitic, viral, and fungal organisms. Therefore, people with HIV infection can develop opportunistic infections while sometimes resisting other more common illnesses.

SUMMARY:

. Ask students:

- Since HIV infection is permanent, what are the best ways to stay healthy?

ACTIVITY SHEET Grade 12

CIVIL RIGHTS ISSUES IN HIV ANTIBODY TESTING

In April 1985, a test became widely available which shows whether or not antibodies to HIV are present in a blood sample. This test is used to screen all donated blood and blood products. Any blood sample which shows these antibodies is not used for transfusion. The test can also indicate whether, at some time in the past, an individual has been exposed to HIV. However, there are many questions about how the test and the results of the test should be used.

When a decision involves the public health, the rights of individuals are weighed against the needs of the public.

At this time, the New York City Department of Health finds that public identification of people with AIDS, or of people who have antibodies in their blood, would not help the general public.

> Because AIDS is not transmitted by casual contact, such as eating, drinking, sneezing, or shaking hands, people do not need to take any special precautions in relating to people with AIDS in social or work situations. Therefore, the public would receive no benefit from knowing which people have AIDS or have antibodies to HIV in their blood.
>
> The public identification of people with AIDS or people with antibodies to HIV in their blood would probably bring discrimination against these people at work, in school, in housing, in insurance. Therefore, the civil rights of these individuals must be carefully guarded.

However, there are still other questions:

1. Should blood donors be told that their blood tested positive?

   A positive test for the antibodies does not mean that these people will definitely get AIDS, only that they have been exposed to HIV. Should these people be subjected to the emotional stress of wondering if they have AIDS when nothing can be done anyway? On the other hand, these people may be infecting others. If these individuals know they have tested positive, they are better able to make decisions not to continue sexual or IV drug activities likely to transmit HIV.

2. Who beside blood donors should be tested? For example, should a test for HIV antibodies be required for a marriage license? (The military has decided to test all personnel.)

3. Should it be the responsibility of those at risk to apply for testing through their own doctors? In New York City, there are some HIV antibody testing centers where people can get the test at no cost, without giving their names, and with no one else knowing their results. Should more centers be set up to make testing more widely available?

ACTIVITY SHEET (continued) Grade 12

4. Should agencies take information from people with positive tests so they can locate and inform their sexual partners or people with whom they have shared IV drug paraphernalia, or should that be the responsibility of the individuals?

5. What kinds of information should be recorded about the people who are tested? For example, should testing centers keep records of individuals, with names and social security numbers, or just statistics on the number of positive test results?

6. If records are kept, what agencies or individuals should have access to these records?

7. What measures can be taken to insure that the recorded information is not used to discriminate against individuals?

Directions: In your group, examine the related question(s) assigned by your teacher. On the lines below record which questions you are assigned, your recommendations, and the reasons for your recommendations.

Question(s)_____

We recommend _____

_____

_____

_____

_____

Because _____

_____

_____

_____

_____

_____

_____

Mr. OWENS. Thank you.

Dr. Wanda Jubb, the Michigan Department of Education.

Ms. JUBB. Thank you. Good morning, Mr. Chairman, members of the committee.

I appreciate this opportunity to share with you the school education efforts being conducted in Michigan to prevent the spread of AIDS.

In April of 1986, our State Board of Education approved a position paper. That position paper encouraged our local school districts to develop a policy dealing with students and/or staff who have contracted AIDS. We sent this to all schools along with the CDC guidelines.

Staff from the Michgan Department of Education and the Michigan Department of Public Health followed by conducting regional workshops to provide a model in-service for school staff. We felt it very necessary for all staff to have an awareness of what AIDS was and how it was transmitted.

By the Fall of 1986, then we moved into developing a response team, a response team made up of members from the Michigan Department of Education, as well as the Michigan Department of Public Health, to assist any local school district upon request if they called upon us to deal with policy, press releases, or questions from the media when they had a case within the school district. That response team has been called upon five times.

In April of 1987, the Department of Education had an opinion poll where they asked parents if they favored the teaching of AIDS in schools. The opinion poll respondents were 94 percent positive that schools should provide to the students information on AIDS. That moved us then into developing our first senior high AIDS curriculum, which we sent to all schools in that Spring of 1987.

We also provided the school districts with a survey requesting, number one, did they have a policy; two, had they provided staff awareness, especially on how to handle all body fluids; and were they providing a curriculum, anything in AIDS education, to students.

We found that they were moving towards policy development—that very little, however plans were in place to provide staff awareness—and also, not really curriculum, but AIDS education—yes, to the point that they at least handed out pamphlets prior to the senior trip.

By July of 1987, the Michigan Department of Education submitted a proposal to the Centers for Disease Control for funding a cooperative agreement to provide a State program for school health education to prevent the spread of AIDS, as well as a second piece was to provide a training demonstration program for other States based upon what Michigan had already in place. We were funded.

Our State objectives, then, in year one, was to have at least 40 percent, which was 210 of our 525 school districts, provide effective AIDS education to students at the junior high and the high school level.

A second objective: to have at least 32 percent or 168 school districts implement a comprehensive school health program which includes effective AIDS education.

That also would include having an appropriate AIDS policy for students and staff with AIDS and community involvement which would include the parents.

The third objective would be to have a significant gain in AIDS-related knowledge of junior high and high school students demonstrated.

Those activities, then, that have been carried forward to accomplish those objectives is to develop an AIDS supplement for our Michigan model comprehensive school health program that we are going into our fourth year with—a program that started at kindergarten and has progressed up through sixth grade. Seventh and eighth grade of the comprehensive school health program is being developed and will be available to our schools by fall.

In the development of AIDS curriculum, then, we have developed a module for seventh and eighth grade, a module for ninth-tenth grade, a module for eleventh-twelfth grade.

Beginning next Monday we will be training trainers to then train the teachers prior to classroom instruction. These modules will be sent to all school districts.

We are meeting with the Michigan PTA to develop a State plan for educating parents, providing parents' input to the local school district policy and curriculum.

We are also providing materials by the means of recommended videos, master transparencies, and student work sheets. This would be part of the curriculum being sent.

We are also participating in a statewide sample survey to provide baseline data on student knowledge, attitudes, and behavior. We feel this is very necessary to base any curriculum change in the future fund.

Then in December, our legislators passed Public Act 185, which mandates AIDS education be taught as a dangerous communicable disease. Under that Public Act we will teach the modes of transmission and the best methods of prevention, and all local school boards will approve the curriculum prior to classroom use.

We have also just conducted an opinion poll of 3,000 students. What are the chances of getting the AIDS virus was one of the questions asked. That opinion poll came back with four percent of the students ranking themselves as high, 13 percent as medium, 43 percent low, only 27 percent saying no risk. However, 14 percent don't know.

One of the other questions on a yes or no: Can you get AIDS by donating blood? Thirty-six percent of our 3,000 students responding said yes. And by a mosquito bite: 25 percent of our students answered yes.

I believe that shows that, yes, we have a good start; yes, we are moving; however, we have a lot of education to do. We are pleased with the assistance from CDC because, as you can tell from the activities that I outlined, we have been able to move much faster in four months than we were in the previous year, plus.

To follow up on the training demonstration, Michigan did hold then one session. We had representatives from 26 States. We were able to complete a needs assessment; and planning has been completed with New York State as to the follow-up sessions that will be held, how we can then assist the States that were not funded,

and are funded but are following in our footsteps of the training that we can provide.

I thank you for this opportunity this morning to share with you.

Mr. OWENS. Thank you.

I want to thank all of our panelists for very informative presentations. Please feel free to elaborate during the question period.

Congressman Jeffords will lead the questioning.

Mr. JEFFORDS. Thank you, Mr. Chairman.

Mr. Tolsma, I wonder if you could tell whether or not your projections for the future incidence of AIDS take into consideration educational programs or are they merely based on the experience that we have had thus far in growth rates?

Mr. TOLSMA. The projections are based on the knowledge about the incubation period and currently infected persons. In other words, people who are already infected will be the people who will be contributing to the cases that emerge as AIDS in the next several years, so they are based on already infected people.

Mr. JEFFORDS. All right, but it does not, then, take into consideration any possible change in behavior due to educational programs?

Mr. TOLSMA. No, because for persons already infected, changes in behavior are not going to affect the likelihood that they get AIDS.

Mr. JEFFORDS. I understand that.

Mr. TOLSMA. If you are talking in terms of what is the likely future number of cases of HIV infected persons, there is no current estimate of what that will be in the future. We are establishing a greatly augmented capability of measuring HIV prevalence in various groups in the population which will give us better information to determine what that level of HIV is. A nationally practiced effective education about AIDS: yes, I think it would influence the course of rate of increase of HIV infection in the population.

Mr. JEFFORDS. I was not referring to your 1 to 1.5. I was referring to other, I guess, projections which have been made, I thought by CDC but perhaps by others, indicating the incidence anticipated in periods of 5, 10 years from now.

Do you have such information?

Mr. TOLSMA. We need better information in order to try to make such estimates and we are setting about to get that information in, for example, the 30 cities, zero prevalence studies. But we have not made a projection at this point in time.

Mr. JEFFORDS. Thank you.

Now I want the panel to focus on the proper Federal role, recognizing, as we all have, that education is our primary, if not the only weapon that we have at this time to try and stop the spread of AIDS. Naturally, this committee—being the Education and Labor Committee—is interested in what role the Federal Government ought to have in trying to assist and to promote educational activities.

First, Mr. Tolsma, you have a number of grants which are going out, a number of Federal grants.

Would you relate to us what you anticipate doing with the data that is collected from such grants? Who is in charge in analyzing the data?

And what purpose do you see that you have or that the Federal Government ought to have with this data that is being collected?

Mr. TOLSMA. The primary purpose of the cooperative agreements that we have written with the State and local education agencies is to accelerate the development and the application of AIDS education for children and youth.

Collecting data is a secondary aspect of the cooperative agreements. Their primary purposes are, as I think you have heard today, to help accelerate the development of local approaches, local curriculum, and to make sure that every child gets an effective education about AIDS.

We will be getting information of a couple of kinds. One is, what is the proportion of young people in each of the assisted States that are getting AIDS education today. That is not a piece of information that we know.

So in order to determine what is the magnitude of the need, we do need a baseline in terms of how many young people already are in AIDS education.

In addition, we will be asking them to examine what was referred to in some of the testimony, how many of these are getting effective AIDS education in the context of a comprehensive approach to school health education.

We will help the States to analyze that data as they request. Each State will be using it, obviously, to plan and direct their programs to where they have uncovered students.

Mr. JEFFORDS. In other words, you have no present plans to try to evaluate the effectiveness of various programs or to make recommendations to other school districts as to wh program is the most effective?

Mr. TOLSMA. In terms of evaluation, each of the grantees was asked to indicate how they would undertake to evaluate their programs. And in fact, we do plan to work with each of them as they carry out their evaluation of programs.

In addition, we have provided assistance to the National Academy of Sciences to develop a report on what is known about health behavior choices that might be able then to be incorporated into AIDS education programs. So that report of the National Academy would be an important vehicle for helping people to determine what should be in their programs and, therefore, what they should be monitoring in terms of what is the effect of that program.

Finally, we have collaborated with the 15 States that are initially assisted in the 1987 award cycle to produce a consensus amongst them of what were the appropriate knowledge attitudes and practices that might be incorporated in survey instruments.

These surveys would be those that would be carried out by the education agencies themselves but they would provide the baseline against which one could examine: Do we see changes and in what direction in the knowledge and the attitudes and the beliefs about AIDS of the young people in these education programs. So we do intend to evaluate effectiveness of programs.

Mr. JEFFORDS. Let me ask the panel now. What do you want from the Federal Government other than money, perhaps, which I know would be probably a unanimous joint request? Ms. Hubbell?

Ms. HUBBELL. I would say that, from the national level as well as the State and local level, of course the funding is an extremely important issue. The funding, though, should be used to work towards research so that we at the State level and the national level can produce effective programs, and present to the States what is best, what is working in those local districts. What we find at the national level is supportive materials. The funding would need to be, I think, produced from the Federal level so that the locals and the State can take best advantage of what is available.

As far as the evaluation, the monitoring, that is extremely important, I believe at the State level, the national level, and the local level.

We need to find out what does work and what is going to work, and what is not working in the educational programs.

All of these issues that are important do need some funds. They also need guidelines, but not real strict guidelines, from the Federal Government, so that the national organizations can best use the information as they find it and develop it, to the States and the States to the locals.

I would say what the Federal Government can do most is to help us in gathering the research, providing the funding, and yet leaving the specifics to the actual programs to the local and State level with not a lot of guidelines and specific information that we must follow.

Mr. JEFFORDS. Dr. Jubb?

Ms. JUBB. Technical assistance, guidelines, as has been stated, that are general enough that we can work with. The actual reporting from the national level back to the States is very helpful. We have leaned upon our Public Health Department who hears regularly from CDC—that has been extremely helpful.

As I was able to point out, definitely funding allows the program to grow that much faster.

Mr. JEFFORDS. Ms. Abelson?

Ms. ABELSON. I would have to support my colleagues in what they have said here.

I would just like to add one more thing and it is in reference to the guidelines. I know in New York State as well as New York City, one of the things we can find out is the impact of AIDS education on behavior, because it deals with those sensitive, explicit topics that everybody is very concerned that we shouldn't deal with. And guidelines that do encourage the fact that we must have that kind of information to evaluate programs as well as to continue to develop more appropriate programs that do address behavior.

We need support in those efforts and support from every level, the State level as well as the Federal Government, that is somehow consistent, and that we can look to when we go out to communities to say: We need to get this information from your children, please help us.

Mr. JEFFORDS. Thank you, Mr. Chairman.

I have to be in another committee. I will be back, but thank you for this opportunity, and I thank the panel.

Mr. OWENS. I would just like to begin my questioning with some clarification of some things that Mr. Tolsma said. You say you spend $136 million on AIDS in general. I think I heard that clear-

ly: $136 million. But I didn't quite understand how much you have spent on AIDS education, AIDS preventive activities.

Mr. TOLSMA. The CDC expenditures in 1987 for AIDS were $136 million. This is the comprehensive program of AIDS education as originally described in the Public Health Information and Education Plan, so it includes in addition to the school and college age children. It also includes the funds expended on information for the general public, information for the persons at risk. These are the risk reduction grants that go out to the——

Mr. OWENS. So $136 million is for AIDS education?

Mr. TOLSMA. In 1987, that is correct.

In 1988, that figure grows substantially to $309 million.

Mr. OWENS. $309 million?

Mr. TOLSMA. $304 million, excuse me—$304.9 million.

Mr. OWENS. For AIDS education ?

Mr. TOLSMA. That is correct—and risk reduction activities, and supportive surveillance mechanisms, for example.

Mr. OWENS. You mentioned guidelines. Are the guidelines already issued? Are they available? Do the other three panelists have sufficient copies of them?

What is the state of the guidelines at this point?

Mr. TOLSMA. CDC has produced two guidelines. The one back in 1985 was addressing children with AIDS in schools and in foster care. The guidelines with regard to school health education were issued on Friday of last week. So, yes, they are out, they are available, and they are in the process of being distributed.

We are in fact asking the people who are awardees of CDC to participate in the distribution to assure that they get to appropriate users. But in addition, we did in advance send copies to each State Superintendent of Education and in to each State Public Health officer so that they got them when they came out on Friday. So they are now moving out into distribution.

Mr. OWENS. So this booklet entitled "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" is the guidelines that were issued last Friday.

Mr. TOLSMA. Yes, it went out to all the MMWR recipients on that date, and in addition, we now are distributing a substantial additional number of them to our awardees.

[The booklet follows:]

CENTERS FOR DISEASE CONTROL

January 29, 1988 / Vol. 37 / No. S-2

MMWR

Supplement

MORBIDITY AND MORTALITY WEEKLY REPORT

Guidelines for Effective School Health Education To Prevent the Spread of AIDS

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
Center for Health Promotion and Education
Atlanta, Georgia 30333

83

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Guidelines for Effective School Health Education To Prevent the Spread of AIDS

Introduction

Since the first cases of acquired immunodeficiency syndrome (AIDS) were reported in the United States in 1981, the human immunodeficiency virus (HIV) that causes AIDS and other HIV-related diseases has precipitated an epidemic unprecedented in modern history. Because the virus is transmitted almost exclusively by behavior that individuals can modify, educational programs to influence relevant behavior can be effective in preventing the spread of HIV (*1-5*).

The guidelines below have been developed to help school personnel and others plan, implement, and evaluate educational efforts to prevent unnecessary morbidity and mortality associated with AIDS and other HIV-related illnesses. The guidelines incorporate principles for AIDS education that were developed by the President's Domestic Policy Council and approved by the President in 1987 (see Appendix I).

The guidelines provide information that should be considered by persons who are responsible for planning and implementing appropriate and effective strategies to teach young people about how to avoid HIV infection. These guidelines should not be construed as rules, but rather as a source of guidance. Although they specifically were developed to help **school personnel**, personnel from other organizations should consider these guidelines in planning and carrying out effective education about AIDS for youth who do **not** attend school and who may be at high risk of becoming infected. As they deliberate about the need for and content of AIDS education, educators, parents, and other concerned members of the community should consider the prevalence of behavior that increases the risk of HIV infection among young people in their communities. Information about the nature of the AIDS epidemic, and the extent to which young people engage in behavior that increases the risk of HIV infection, is presented in Appendix II.

Information contained in this document was developed by CDC in consultation with individuals appointed to represent the following organizations:

American Academy of Pediatrics
American Association of School Administrators
American Public Health Association
American School Health Association
Association for the Advancement of Health Education
Association of State and Territorial Health Officers
Council of Chief State School Officers
National Congress of Parents and Teachers
National Council of Churches

National Education Association
National School Boards Association
Society of State Directors of Health, Physical Education, Recreation and Dance
U.S. Department of Education
U.S. Food and Drug Administration
U.S. Office of Disease Prevention and Health Promotion

Consultants included a director of health education for a state department of education, a director of curriculum and instruction for a local education department, a health education teacher, a director of school health programs for a local school district, a director of a state health department, a deputy director of a local health department, and an expert in child and adolescent development.

Planning and Implementing Effective School Health Education about AIDS

The Nation's public and private schools have the capacity and responsibility to help assure that young people understand the nature of the AIDS epidemic and the specific actions they can take to prevent HIV infection, especially during their adolescence and young adulthood. The specific scope and content of AIDS education in schools should be locally determined and should be consistent with parental and community values.

Because AIDS is a fatal disease and because educating young people about becoming infected through sexual contact can be controversial, school systems should obtain broad community participation to ensure that school health education policies and programs to prevent the spread of AIDS are locally determined and are consistent with community values.

The development of school district policies on AIDS education can be an important first step in developing an AIDS education program. In each community, representatives of the school board, parents, school administrators and faculty, school health services, local medical societies, the local health department, students, minority groups, religious organizations, and other relevant organizations can be involved in developing policies for school health education to prevent the spread of AIDS. The process of policy development can enable these representatives to resolve various perspectives and opinions, to establish a commitment for implementing and maintaining AIDS education programs, and to establish standards for AIDS education program activities and materials. Many communities already have school health councils that include representatives from the aforementioned groups. Such councils facilitate the development of a broad base of community expertise and input, and they enhance the coordination of various activities within the comprehensive school health program (6).

AIDS education programs should be developed to address the needs and the developmental levels of students and of school-age youth who do not attend school, and to address specific needs of minorities, persons for whom English is not the primary language, and persons with visual or hearing impairments or other learning disabilities. Plans for addressing students' questions or concerns about AIDS at the early elementary grades, as well as for providing effective school health education about AIDS at each grade from late elementary/middle school through junior

high/senior high school, including educational materials to be used, should be reviewed by representatives of the school board, appropriate school administrators, teachers, and parents before being implemented.

Education about AIDS may be most appropriate and effective when carried out within a more comprehensive school health education program that establishes a foundation for understanding the relationships between personal behavior and health (*7-9*). For example, education about AIDS may be more effective when students at appropriate ages are more knowledgeable about sexually transmitted diseases, drug abuse, and community health. It may also have greater impact when they have opportunities to develop such qualities as decision-making and communication skills, resistance to persuasion, and a sense of self-efficacy and self-esteem. However, education about AIDS should be provided as rapidly as possible, even if it is taught initially as a separate subject.

State departments of education and health should work together to help local departments of education and health throughout the state collaboratively accomplish effective school health education about AIDS. Although all schools in a state should provide effective education about AIDS, priority should be given to areas with the highest reported incidence of AIDS cases.

Preparation of Education Personnel

A team of representatives including the local school board, parent-teachers associations, school administrators, school physicians, school nurses, teachers, educational support personnel, school counselors, and other relevant school personnel should receive general training about a) the nature of the AIDS epidemic and means of controlling its spread, b) the role of the school in providing education to prevent transmission of HIV, c) methods and materials to accomplish effective programs of school health education about AIDS, and d) school policies for students and staff who may be infected. In addition, a team of school personnel responsible for teaching about AIDS should receive more specific training about AIDS education. All school personnel, especially those who teach about AIDS, periodically should receive continuing education about AIDS to assure that they have the most current information about means of controlling the epidemic, including up-to-date information about the most effective health education interventions available. State and local departments of education and health, as well as colleges of education, should assure that such in-service training is made available to all schools in the state as soon as possible and that continuing in-service and pre-service training is subsequently provided. The local school board should assure that release time is provided to enable school personnel to receive such in-service training.

Programs Taught by Qualified Teachers

In the elementary grades, students generally have one regular classroom teacher. In these grades, education about AIDS should be provided by the regular classroom teacher because that person ideally should be trained and experienced in child development, age-appropriate teaching methods, child health, and elementary health education methods and materials. In addition, the elementary teacher usually is sensitive to normal variations in child development and aptitudes within a class. In the secondary grades, students generally have a different teacher for each subject. In

these grades, the secondary school health education teacher preferably should provide education about AIDS, because a qualified health education teacher will have training and experience in adolescent development, age-appropriate teaching methods, adolescent health, and secondary school health education methods and materials (including methods and materials for teaching about such topics as human sexuality, communicable diseases, and drug abuse). In secondary schools that do not have a qualified health education teacher, faculty with similar training and good rapport with students should be trained specifically to provide effective AIDS education.

Purpose of Effective Education about AIDS

The principal purpose of education about AIDS is to prevent HIV infection. The content of AIDS education should be developed with the active involvement of parents and should address the broad range of behavior exhibited by young people. Educational programs should assure that young people acquire the knowledge and skills they will need to adopt and maintain types of behavior that virtually eliminate their risk of becoming infected.

School systems should make programs available that will enable and encourage young people who **have not** engaged in sexual intercourse and who **have not** used illicit drugs to continue to–

- Abstain from sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
- Refrain from using or injecting illicit drugs.

For young people who **have** engaged in sexual intercourse or who **have** injected illicit drugs, school programs should enable and encourage them to–

- Stop engaging in sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
- To stop using or injecting illicit drugs.

Despite all efforts, some young people may remain unwilling to adopt behavior that would virtually eliminate their risk of becoming infected. Therefore, school systems, in consultation with parents and health officials, should provide AIDS education programs that address preventive types of behavior that should be practiced by persons with an increased risk of acquiring HIV infection. These include:

- Avoiding sexual intercourse with anyone who is known to be infected, who is at risk of being infected, or whose HIV infection status is not known;
- Using a latex condom with spermicide if they engage in sexual intercourse;
- Seeking treatment if addicted to illicit drugs;
- Not sharing needles or other injection equipment;
- Seeking HIV counseling and testing if HIV infection is suspected.

State and local education and health agencies should work together to assess the prevalence of these types of risk behavior, and their determinants, over time.

Content

Although information about the biology of the AIDS virus, the signs and symptoms of AIDS, and the social and economic costs of the epidemic might be of interest, such information is not the essential knowledge that students must acquire in order to prevent becoming infected with HIV. Similarly, a single film, lecture, or school assembly about AIDS will not be sufficient to assure that students develop the complex understanding and skills they will need to avoid becoming infected.

Schools should assure that students receive at least the essential information about AIDS, as summarized in sequence in the following pages, for each of three grade-level ranges. The exact grades at which students receive this essential information should be determined locally, in accord with community and parental values, and thus may vary from community to community. Because essential information for students at higher grades requires an understanding of information essential for students at lower grades, secondary school personnel will need to assure that students understand basic concepts before teaching more advanced information. Schools simultaneously should assure that students have opportunitites to learn about emotional and social factors that influence types of behavior associated with HIV transmission.

Early Elementary School

Education about AIDS for students in early elementary grades principally should be designed to allay excessive fears of the epidemic and of becoming infected.

AIDS is a disease that is causing some adults to get very sick, but it does not commonly affect children.

AIDS is very hard to get. You cannot get it just by being near or touching someone who has it.

Scientists all over the world are working hard to find a way to stop people from getting AIDS and to cure those who have it.

Late Elementary/Middle School

Education about AIDS for students in late elementary/middle school grades should be designed with consideration for the following information.

Viruses are living organisms too small to be seen by the unaided eye.

Viruses can be transmitted from an infected person to an uninfected person through various means.

Some viruses cause disease among people.

Persons who are infected with some viruses that cause disease may not have any signs or symptoms of disease.

AIDS (an abbreviation for acquired immunodeficiency syndrome) is caused by a virus that weakens the ability of infected individuals to fight off disease.

People who have AIDS often develop a rare type of severe pneumonia, a cancer called Kaposi's sarcoma, and certain other diseases that healthy people normally do not get.

About 1 to 1.5 million of the total population of approximately 240 million Americans currently are infected with the AIDS virus and consequently are capable of infecting others.

People who are infected with the AIDS virus live in every state in the United States and in most other countries of the world. Infected people live in cities as well as in suburbs, small towns, and rural areas. Although most infected people are adults, teenagers can also become infected. Females as well as males are infected. People of every race are infected, including whites, blacks, Hispanics, Native Americans, and Asian/Pacific Islanders.

The AIDS virus can be transmitted by sexual contact with an infected person; by using needles and other injection equipment that an infected person has used; and from an infected mother to her infant before or during birth.

A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.

It sometimes takes several years after becoming infected with the AIDS virus before symptoms of the disease appear. Thus, people who are infected with the virus can infect other people—even though the people who transmit the infection do not feel or look sick.

Most infected people who develop symptoms of AIDS only live about 2 years after their symptoms are diagnosed.

The AIDS virus cannot be caught by touching someone who is infected, by being in the same room with an infected person, or by donating blood.

Junior High/Senior High School

Education about AIDS for students in junior high/senior high school grades should be developed and presented taking into consideration the following information.

The virus that causes AIDS, and other health problems, is called human immunodeficiency virus, or HIV.

The risk of becoming infected with HIV can be virtually eliminated by not engaging in sexual activities and by not using illegal intravenous drugs.

Sexual transmission of HIV is not a threat to those uninfected individuals who engage in mutually monogamous sexual relations.

HIV may be transmitted in any of the following ways: a) by sexual contact with an infected person (penis/vagina, penis/rectum, mouth/vagina, mouth/penis, mouth/rectum); b) by using needles or other injection equipment that an infected person has used; c) from an infected mother to her infant before or during birth.

A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.

The following are at increased risk of having the virus that causes AIDS and consequently of being infectious: a) persons with clinical or laboratory evidence of

infection; b) males who have had sexual intercourse with other males; c) persons who have injected illegal drugs; d) persons who have had numerous sexual partners, including male or female prostitutes; e) persons who received blood clotting products before 1985; f) sex partners of infected persons or persons at increased risk; and g) infants born to infected mothers.

The risk of becoming infected is increased by having a sexual partner who is at increased risk of having contracted the AIDS virus (as identified previously), practicing sexual behavior that results in the exchange of body fluids (i.e., semen, vaginal secretions, blood), and using unsterile needles or paraphernalia to inject drugs.

Although no transmission from deep, open-mouth (i.e., "French") kissing has been documented, such kissing theoretically could transmit HIV from an infected to an uninfected person through direct exposure of mucous membranes to infected blood or saliva.

In the past, medical use of blood, such as transfusing blood and treating hemophiliacs with blood clotting products, has caused some people to become infected with HIV. However, since 1985 all donated blood has been tested to determine whether it is infected with HIV; moreover, all blood clotting products have been made from screened plasma and have been heated to destroy any HIV that might remain in the concentrate. Thus, the risk of becoming infected with HIV from blood transfusions and from blood clotting products is virtually eliminated. Cases of HIV infection caused by these medical uses of blood will continue to be diagnosed, however, among people who were infected by these means before 1985.

Persons who continue to engage in sexual intercourse with persons who are at increased risk or whose infection status is unknown should use a latex condom (not natural membrane) to reduce the likelihood of becoming infected. The latex condom must be applied properly and used from start to finish for every sexual act. Although a latex condom does not provide 100% protection—because it is possible for the condom to leak, break, or slip off—it provides the best protection for people who do not maintain a mutually monogamous relationship with an uninfected partner. Additional protection may be obtained by using spermicides that seem active against HIV and other sexually transmitted organisms in conjunction with condoms.

Behavior that prevents exposure to HIV also may prevent unintended pregnancies and exposure to the organisms that cause Chlamydia *infection, gonorrhea, herpes, human papillomavirus, and syphilis.*

Persons who believe they may be infected with the AIDS virus should take precautions not to infect others and to seek counseling and antibody testing to determine whether they are infected. If persons ***are not*** *infected, counseling and testing can relieve unnecessary anxiety and reinforce the need to adopt or continue practices that reduce the risk of infection. If persons* ***are*** *infected, they should: a) take precautions to protect sexual partners from becoming infected; b) advise previous and current sexual or drug-use partners to receive counseling and testing; c) take precautions against becoming pregnant; and d) seek medical care*

and counseling about other medical problems that may result from a weakened immunologic system.

More detailed information about AIDS, including information about how to obtain counseling and testing for HIV, can be obtained by telephoning the AIDS National Hotline (toll free) at 800-342-2437; the Sexually Transmitted Diseases National Hotline (toll free) at 800-227-8922; or the appropriate state or local health department (the telephone number of which can be obtained by calling the local information operator).

Curriculum Time and Resources

Schools should allocate sufficient personnel time and resources to assure that policies and programs are developed and implemented with appropriate community involvement, curricula are well-planned and sequential, teachers are well-trained, and up-to-date teaching methods and materials about AIDS are available. In addition, it is crucial that sufficient classroom time be provided at **each** grade level to assure that students acquire essential knowledge appropriate for that grade level, and have time to ask questions and discuss issues raised by the information presented.

Program Assessment

The criteria recommended in the foregoing "Guidelines for Effective School Health Education To Prevent the Spread of AIDS" are summarized in the following nine assessment criteria. Local school boards and administrators can assess the extent to which their programs are consistent with these guidelines by determining the extent to which their programs meet each point shown below. Personnel in state departments of education and health also can use these criteria to monitor the extent to which schools in the state are providing effective health education about AIDS.

1. To what extent are parents, teachers, students, and appropriate community representatives involved in developing, implementing, and assessing AIDS education policies and programs?
2. To what extent is the program included as an important part of a more comprehensive school health education program?
3. To what extent is the program taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades?
4. To what extent is the program designed to help students acquire essential knowledge to prevent HIV infection at each appropriate grade?
5. To what extent does the program describe the benefits of abstinence for young people and mutually monogamous relationships within the context of marriage for adults?
6. To what extent is the program designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with HIV?
7. To what extent is adequate training about AIDS provided for school administrators, teachers, nurses, and counselors—especially those who teach about AIDS?

8. To what extent are sufficient program development time, classroom time, and educational materials provided for education about AIDS?
9. To what extent are the processes and outcomes of AIDS education being monitored and periodically assessed?

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Appendix I

The President's Domestic Policy Council's Principles for AIDS Education

The following principles were proposed by the Domestic Policy Council and approved by the President in 1987:

Despite intensive research efforts, prevention is the only effective AIDS control strategy at present. Thus, there should be an aggressive Federal effort in AIDS education.

The scope and content of the school portion of this AIDS education effort should be locally determined and should be consistent with parental values.

The Federal role should focus on developing and conveying accurate health information on AIDS to the educators and others, not mandating a specific school curriculum on this subject, and trusting the American people to use this information in a manner appropriate to their community's needs.

Any health information developed by the Federal Government that will be used for education should encourage responsible sexual behavior—based on fidelity, commitment, and maturity, placing sexuality within the context of marriage.

Any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex and should be used with the consent and involvement of parents.

Appendix II

The Extent of AIDS and Indicators of Adolescent Risk

Since the first cases of acquired immunodeficiency syndrome (AIDS) were reported in the United States in 1981, the human immunodeficiency virus (HIV) that causes AIDS and other HIV-related diseases has precipitated an epidemic unprecedented in modern history. Although in 1985, fewer than 60% of AIDS cases in the United States were reported among persons residing outside New York City and San Francisco, by 1991 more than 80% of the cases will be reported from other localities (*1*).

It has been estimated that from 1 to 1.5 million persons in the United States are infected with HIV (*1*), and, because there is no cure, infected persons are potentially capable of infecting others indefinitely. It has been predicted that 20%-30% of individuals currently infected will develop AIDS by the end of 1991 (*1*). Fifty percent of those diagnosed as having AIDS have not survived for more than about 1.5 years beyond diagnosis, and only about 12% have survived for more than 3 years (*2*).

By the end of 1987, about 50,000 persons in the United States had been diagnosed as having AIDS, and about 28,000 had died from the disease (*2*). Blacks and Hispanics,

who make up about 12% and 6% of the U.S. population, respectively, disproportionately have contracted 25% and 14% of all reported AIDS cases (*3*). It has been estimated that during 1991, 74,000 cases of AIDS will be diagnosed, and 54,000 persons will die from the disease. By the end of that year, the total number of deaths caused by AIDS will be about 179,000 (*1*). In addition, health care and supportive services for the 145,000 persons projected to be living with AIDS in that year will cost our Nation an estimated $8-$10 billion in 1991 alone (*1*). The World Health Organization projects that by 1991, 50-100 million persons may be infected worldwide (*4*). The magnitude and seriousness of this epidemic requires a systematic and concerted response from almost every institution in our society.

A vaccine to prevent transmission of the virus is not expected to be developed before the next decade, and its use would not affect the number of persons already infected by that time. A safe and effective antiviral agent to treat those infected is not expected to be available for general use within the next several years. The Centers for Disease Control (*5*), the National Academy of Sciences (*6*), the Surgeon General of the United States (*7*), and the U.S. Department of Education (*8*) have noted that in the absence of a vaccine or therapy, educating individuals about actions they can take to protect themselves from becoming infected is the most effective means available for controlling the epidemic. Because the virus is transmitted almost exclusively as a result of behavior individuals can modify (e.g., by having sexual contact with an infected person or by sharing intravenous drug paraphernalia with an infected person), educational programs designed to influence relevant types of behavior can be effective in controlling the epidemic.

A significant number of teenagers engage in behavior that increases their risk of becoming infected with HIV. The percentage of metropolitan teenage girls who had ever had sexual intercourse increased from 30%-45% between 1971 and 1982. The average age at first intercourse for females remained at approximately 16.2 years between 1971 and 1979 (*9*). The average proportion of never-married teenagers who have ever had intercourse increases with age from 14 through 19 years. In 1982, the percentage of never-married girls who reported having engaged in sexual intercourse was as follows: approximately 6% among 14-year-olds (*10*), 18% among 15-year-olds, 29% among 16-year-olds, 40% among 17-year-olds, 54% among 18-year-olds, and 66% among 19-year-olds (*11*). Among never-married boys living in metropolitan areas, the percentage who reported having engaged in sexual intercourse was as follows: 24% among 14-year-olds, 35% among 15-year-olds, 45% among 16-year olds, 56% among 17-year-olds, 66% among 18-year olds, and 78% among 19-year olds (*9,12*). Rates of sexual experience (e.g., percentage having had intercourse) are higher for black teenagers than for white teenagers at every age and for both sexes (*11,12*).

Male homosexual intercourse is an important risk factor for HIV infection. In one survey conducted in 1973, 5% of 13- to 15-year-old boys and 17% of 16- to 19-year-old boys reported having had at least one homosexual experience. Of those who reported having had such an experience, most (56%) indicated that the first homosexual experience had occurred when they were 11 or 12 years old. Two percent reported that they currently engaged in homosexual activity (*13*).

Another indicator of high-risk behavior among teenagers is the number of cases of sexually transmitted diseases they contract. Approximately 2.5 million teenagers are affected with a sexually transmitted disease each year (*14*).

Some teenagers also are at risk of becoming infected with HIV through illicit intravenous drug use. Findings from a national survey conducted in 1986 of nearly 130 high schools indicated that although overall illicit drug use seems to be declining slowly among high school seniors, about 1% of seniors reported having used heroin and 13% reported having used cocaine within the previous year (*15*). The number of seniors who injected each of these drugs is not known.

Only 1% of all the persons diagnosed as having AIDS have been under age 20 (*2*); most persons in this group had been infected by transfusion or perinatal transmission. However, about 21% of all the persons diagnosed as having AIDS have been 20-29 years of age. Given the long incubation period between HIV infection and symptoms that lead to AIDS diagnosis (3 to 5 years or more), some fraction of those in the 20- to 29-year-age group diagnosed as having AIDS were probably infected while they were still teenagers.

Among military recruits screened in the period October 1985-December 1986, the HIV seroprevalence rate for persons 17-20 years of age (0.6/1,000) was about half the rate for recruits in all age groups (1.5/1,000) (*16*). These data have lead some to conclude that teenagers and young adults have an appreciable risk of infection and that the risk may be relatively constant and cumulative (*17*).

Reducing the risk of HIV infection among teenagers is important not only for their well-being but also for the children they might produce. The birth rate for U.S. teenagers is among the highest in the developed world (*18*); in 1984, this group accounted for more than 1 million pregnancies. During that year the rate of pregnancy among sexually active teenage girls 15-19 years of age was 233/1,000 girls (*19*).

Although teenagers are at risk of becoming infected with and transmitting the AIDS virus as they become sexually active, studies have shown that they do not believe they are likely to become infected (*20,21*). Indeed, a random sample of 860 teenagers (ages 16-19) in Massachusetts revealed that, although 70% reported they were sexually active (having sexual intercourse or other sexual contact), only 15% of this group reported changing their sexual behavior because of concern about contracting AIDS. Only 20% of those who changed their behavior selected effective methods such as abstinence or use of condoms (*20*). Most teenagers indicated that they want more information about AIDS (*20,21*).

Most adult Americans recognize the early age at which youth need to be advised about how to protect themselves from becoming infected with HIV and recognize that the schools can play an important role in providing such education. When asked in a November 1986 nationwide poll whether children should be taught about AIDS in school, 83% of Americans agreed, 10% disagreed, and 7% were not sure (*22*). According to information gathered by the United States Conference of Mayors in December of 1986, 40 of the Nation's 73 largest school districts were providing education about AIDS, and 24 more were planning such education (*23*). Of the districts that offered AIDS education, 63% provided it in 7th grade, 60% provided it in 9th grade, and 90% provided it in 10th grade. Ninety-eight percent provided medical facts about AIDS, 78% mentioned abstinence as a means of avoiding infection, and 70% addressed the issues of avoiding high-risk sexual activities, selecting sexual partners, and using condoms. Data collected by the National Association of State Boards of Education in the summer of 1987 indicated that a) 15 states had mandated comprehensive school health education; eight had mandated AIDS education; b) 12 had legislation pending on AIDS education, and six had state board of education

actions pending; c) 17 had developed curricula for AIDS education, and seven more were developing such materials; and d) 40 had developed policies on admitting students with AIDS to school (*24*).

The Nation's system of public and private schools has a strategic role to play in assuring that young people understand the nature of the epidemic they face and the specific actions they can take to protect themselves from becoming infected—especially during their adolescence and young adulthood. In 1984, 98% of 14 and 15 year-olds, 92% of 16 and 17 year-olds, and 50% of 18 and 19 year-olds were in school (*25*). In that same year, about 615,000 14- to 17-year-olds and 1.1 million 18- to 19-year-olds were not enrolled in school and had not completed high school (*26*).

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Mr. OWENS. What is your first printing?

Mr. TOLSMA. I believe it is 50,000. In addition to the 100,000 that go out on the standard MMWR distribution, we are printing 50,000 additional.

Mr. OWENS. 100,000 went out on your standard distribution?

Mr. TOLSMA. That is correct.

Mr. OWENS. And you are printing an additional 50,000?

Mr. TOLSMA. That is right.

Mr. OWENS. This is the document for guidelines for the entire country?

Mr. TOLSMA. It is aimed at an audience of educators, educational decision-makers, community leaders, and so on. So that they are the ones who will be making the decisions about what goes into the classroom and that is the primary audience, yes.

Mr. OWENS. What do you plan for your additional printings?

Mr. TOLSMA. We will see what kind of additional requests. It is my understanding that a number of jurisdictions will be reprinting it or issuing their own supplemental guidance based on that.

It was put together by an array of people, including educators, educational psychologists, Public Health people. Its adoption and adaptation at State and local levels may well engender their own specific State or local guidelines based on that.

Mr. OWENS. Ms. Abelson, how many copies do you need in New York City?

Ms. ABELSON. Several thousand, at least, as well as the fact that we have—what happens with us is we have the Federal guidelines, the State guidelines, and then New York City. And while we are part of the State Department of Education, what happens to those guidelines and how they get interpreted, or re-interpreted in New York has yet to be dealt with since we just received them.

Mr. OWENS. So you don't think these guidelines are of particular value?

Ms. ABELSON. No, I am saying I have not had the opportunity to see it. I think they are valuable but I am just saying, our City Department of Health is—the City Board of Education meeting, and we are viewing those guidelines is another policy level.

Mr. OWENS. Did the three of you see drafts of the guidelines before they were produced? Ms. Hubbell? Dr. Jubb? Are you familiar with the guidelines?

Ms. HUBBELL. I did not, but I assume the staff of the State Department at the National Association had an opportunity, but as a State board member I did not view them as a staff member might have.

Mr. OWENS. Mr. Tolsma, how does this compare to the Surgeon General's report on AIDS? Millions of copies of that have been printed and distributed.

Mr. TOLSMA. Yes.

Mr. OWENS. Do you expect millions eventually to be printed of this as a document of similar impact and worth?

Mr. TOLSMA. Obviously if there is a need for additional copies, we will certainly try to make sure that people who need them get them.

The Surgeon General's report was intended as a document for a broad range of people and is a fundamental and basic document which we have tried to use in developing these guidelines.

The target audience for these guidelines is primarily the education and health education community, the school boards, the decision-makers. If we need more copies we will definitely get to them.

But I think as was indicated by Ms. Ablson, I would hope that what would emerge is not necessarily simply redistributing these guidelines to classroom teachers, for example, but incorporating them into a document that reflected the local systems' particular needs and interests in that area. So we will assure that whoever needs them gets copies.

But we would like to see them considered carefully by the State and local decision-makers. And then direct their guidelines to their own classroom teachers.

Mr. OWENS. My concern is that we have said we have an epidemic, that there is a need for more of a sense of urgency. I wonder when vital guidelines like these are being produced in such small quantities, do we understand what a sense of urgency for the whole Nation means; how big this Nation is, and what it means to saturate even the educators with a document of this kind. I think you are underestimating your need and should reconsider the amount of your printing and your whole distribution apparatus immediately.

I think the testimony of Ms. Abelson also bothers me a great deal because it says that in the area of the Nation which we all understand to be the area of highest risk, or one of the two areas of highest risk—New York City—there is really no sense of urgency which matches the risk.

It is a life-threatening disease and that risk population that is under the jurisdiction of the Board of Education—and young people in high school certainly could be considered to be the people of very high risk. And yet you are saying that really no priority has been assigned to it—there's talk. But from the way you enunciate the actual execution of a program, you can't get people to come to training sessions. And if you had more trainers, and had more funds, given the attitude, they would not be very effective because somewhere at the highest levels the message has not gotten through that this is really a high priority—a life-threatening situation which not only affects and impacts on individuals, but given the high numbers, whole communities; and the city as a whole in terms of its budget structure, in terms of its hospital structure, and the great amounts of funds that will be required to take care of people—the city as a whole, its economy is threatened. And yet, people are coasting, it appears.

Did I understand correctly?

Ms. ABELSON. Yes and no.

Let me clarify one thing. As of the Spring of 1988, every student in every high school in New York got at least two lessons under the new mandate on AIDS education. The following spring, every graduating senior saw the video, Sex, Drugs and AIDS, and received two additional lessons.

What I am saying is, the expanded six-lesson per grade, 7 through 12 curriculum, will demand much more effort than two

lessons—for every student that was the same that was done over a mass produced type of period. So that the urgency was felt and a charge was met. The high schools did indeed implement AIDS education and mandated it. It was a mandate from the Central Board and the Chancellor's office.

What I am saying is, once it gets down to the district level where the position of any mandate and who is controlling what show becomes a little bit more debatable and arguable. And once it comes down to the actual district level and school based implementation, that is where we are also having difficulties. A mandate on the middle schools for every grade that goes beyond and supersedes the SED mandate for K through 12 and comprehensive would certainly help the problem we have in the middle school area.

But what I am saying is that people that are in charge of the school systems on a district level, from the superintendent's office through the community school district and into the classrooms, need to really get behind this in a more effective way.

Mr. OWENS. Don't misunderstand me, I appreciate your testimony, but let me just ask you a few more penetrating questions.

Ms. ABELSON. No problem.

Mr. OWENS. What is your title?

Ms. ABELSON. I am the Project Director for AIDS Education.

Mr. OWENS. In what office?

Ms. ABELSON. Office of Health, Physical Education and School Sports out of the Curriculum and Instruction Division.

Mr. OWENS. What level are you within the Board of Education structure?

How much authority do you have over——

Ms. ABELSON. More responsibility than authority. I may write the Chancellor's memos but they go through several lines and several political levels.

Mr. OWENS. Oh, you have a Chancellor?

Ms. ABELSON. Well, no, the Acting Chancellor at this point.

Mr. OWENS. There's a Chancellor?

Ms. ABELSON. Right.

Mr. OWENS. Then there are some Deputy Chancellors?

Ms. ABELSON. There is a Deputy Chancellor.

Mr. OWENS. Who is under that?

Ms. ABELSON. The Director of Curriculum Instruction.

Mr. OWENS. The Director of Curriculum Instruction?

Ms. ABELSON. Then the Director of Health and Physical Education?

Mr. OWENS. Director of Health and Physical Education?

Ms. ABELSON. Then myself.

Mr. OWENS. Then yourself.

So here is a priority, life-threatening program, high-risk population, and we have to go down five or six levels before we get to the person who is in charge of it.

I think that is a serious situation in terms of the assignment of priority to this—you know, with all due respect to the job that you are doing.

Mr. BIAGGI. Mr. Chairman?

Mr. OWENS. You can't command the authority necessary to make people listen to you at the district levels out there if you don't have

it at a higher level. I am very concerned about whether or not we really have made it a priority in New York City .

I yield to my colleague from New York, Congressman Biaggi.

Mr. BIAGGI. On that point, you gave us a number of titles.

Let me ask you what I think is a critical question. Any comment or recommendation you make goes through the——

Ms. ABELSON. Absolutely—every proposal——

Mr. BIAGGI. You don't have direct access to the Chancellor?

Ms. ABELSON. Oh, no.

Mr. BIAGGI. Your facial expression and the immediacy of your response indicates to me that would be absolutely verbatim.

Ms. ABELSON. I would expect that you are familiar with the structure and the politics——

Mr. BIAGGI. I want this for the record.

Ms. ABELSON. Oh, yes. I can't only speak to—knowing that everything I do has to go through my boss, and her boss, and up to the Chancellor's assistants, before any action is taken—and that certainy is a long-term thing.

We have gotten the charge and we were very pleased to have an initial mandate at the point in which we did, but as Congressman Owens' says, the immediacy and the degree to which we must implement and program demands much greater effort.

Mr. BIAGGI. Your response reinforces the chairman's concern about priority. That is the only reason I interrupted.

Thank you, Mr. Chairman.

Mr. OWENS. You say that the State has mandated in Kansas and Michigan, that there will be AIDS education. And then you say how it is done is left up to the local level.

What are we saying, that a local school district can elect to put a paragraph into a health curriculum about AIDS and that would be sufficient? Or are you saying that the State in its mandates sets certain standards and those standards have to be adhered to as the local level education agency develops its curriculum?

Dr. Jubb, and then Ms. Hubbell.

Ms. JUBB. I would say that our State mandate only says that the mode of transmission and best method of prevention is listed—does not give which grades, every student. However, I believe with State leadership doing its job and school districts contacting us and saying, what can we do; what should we be doing—if we provide them with the curriculum and teacher training, and the support that they need, bottom line, the local school board will still approve prior to going into the classroom with that curriculum. It is not that we want to put——

Mr. OWENS. But they have the power and the authority to have a minimal program?

Ms. JUBB. They do have.

Mr. OWENS. Ms. Hubbell?

Ms. HUBBELL. In Kansas it is very similar. The State will mandate that every school district, by next fall, must have AIDS education at the elementary and secondary level.

We are saying they must have a comprehensive health education program, including the teaching of sexually transmitted diseases, including AIDS. We found originally that 50 percent of the districts in Kansas had health education; very few, until last year, had any

AIDS education. Each school district must provide AIDS education at their elementary level and their secondary level.

We have provided those districts with a comprehensive set of guidelines—kindergarten through twelfth grade. What we recommend should be included in the education of those youth at each age level. At the younger age levels we will talk about self-esteem, talk about parts of their bodies. Fourth, fifth, sixth grade level you actually get into talking about the disease AIDS——

Mr. OWENS. Depending on the local education agency, what they decide to talk about.

Ms. HUBBELL. They will make the final decision in our local controlled State also.

Mr. OWENS. How do the guidelines that are being issued by the CDC—how will they help make that a more effective process so that at the local level, it is more likely that you will have programs of substance? Will the CDC guidelines help; the Surgeon General's report help?

Ms. HUBBELL. Definitely.

Mr. OWENS. The Federal Government is not going to get into the business of setting standards and making mandates in this area just as they have not done so in any other areas of curriculum.

So what can the Federal Government do to help the process produce a situation which is effective, not just a theoretical construct which says we are doing it and we are complying with the mandate? What else can we do to make it more effective?

Ms. HUBBELL. I think from one of your questions, the CDC guidelines, the Surgeon General's report, are all on file at our State Department of Education and at the local school districts will have information such as that information.

I just had a teacher yesterday talk to me about how difficult it is to gather all the information and make the correct decisions on what is the best curriculum.

So at the State and Federal level we can provide that information for the local district so they do incorporate an excellent comprehensive program on AIDS. There is so much material out there that at the State level we also have a list of the curricula materials that are available. The policy guidelines that CDC recommended have been adopted by our State and our local school districts on the attendance of a student in school and this faculty if and when they would contract AIDS.

So I believe the Federal Government, being able to collect this material, CDC being able to provide the information to the State, is a tremendous advantage. There is a tremendous amount of material out there that we as local educators have to disseminate through and pick out what is best for our local district.

I might also add that every local district in Kansas will have their curriculum plan on file at the local school board and at the State school board and will tell us what they are teaching. If funds are provided in Kansas, they must have guidelines and specific curriculum identified before they will receive the funds so we can identify that those funds are being put to good use.

Mr. TOLSMA. Mr. Chairman, if I might offer a comment on that as well?

Mr. OWENS. Yes, Mr. Tolsma?

Mr. TOLSMA. Ms. Hubbell is also with the National Association of State Boards of Education. The national organizations that I mentioned earlier in my testimony that are in cooperative agreements with CDC include such organizations as the National School Boards Association—these are members of local school boards, the decision-makers at the local level—and the American Association of School Administrators, who are basically the school system superintendents—the district superintendents.

These organizations have available to them networks of communication—they have their annual conference. Over 12,000 school board members gather at the annual Conference of the National Association of School Boards.

Our interest in being in a cooperative agreement relationship with them is that these are people who will be advising their members, who will be reflecting the views of their members down through communications channels, they will be putting on workshops, training sessions for new school board members, for example, is one of their program actions.

These are ways to help get the documentation of the need for AIDS education and the kinds of information that these folks participated with us in developing in these guidelines down to the people who will have to make these decisions.

So you have very rightly noted that decision-making on education is extremely pluralistic and local in nature, and we do have organizations—also the National Congress of Parent and Teachers Association—to involve in helping to extend the need for AIDS education throughout their local networks. I think that is one of the things that also will help to accelerate AIDS education decision-making.

Mr. OWENS. I think the President and a few others have used the figure of speech that we are declaring war on AIDS, declaring war.

Do you consider your effort to be that of a high command in charge of a war effort, that there is a sense of urgency, and everything that can be done is being done at this point to contain this before they break out, and the war will be much more difficult to win?

Mr. TOLSMA. I certainly see it as a state of urgency, indeed. There is, fortunately for us, an enormous army of people in the education community. And my sense of most of those people is that they are very concerned about the health of young people and feel that they can make a difference by giving them the facts about AIDS and giving them the skills to make decisions, they can make a difference, and that makes me feel that what we do daily in our work is worthwhile because we educate no one—these people do all the education.

Mr. OWENS. My last question to the three educators is, must AIDS education always be synonymous with sex education?

Is it possible that this great shortage of people to teach AIDS or this problem that you have with respect to getting health programs in the curriculum which will teach AIDS can be alleviated to some degree by the fact that all States require that high school students take a certain number of science courses?

What about science courses? I remember reading Microbe Hunters—we are engaged in a war against those little invisible enemies

out there that won't go away. They are going to be around for as long as there is an earth, for as long as humankind exists there is going to be one epidemic of this kind of another, as populations are more mobile and we know that these little invisible enemies do adjust to everything you use to fight them—they adjust, and they come back with new forms. So the likelihood that there are going to be diseases, strange diseases, very fatal and deadly diseases, masked diseases, is great.

So is this not a challenge for the scientific community, and cannot that be communicated and handled in a high school curriculum as well as through the health department or the health curriculum?

Ms. ABELSON. We plan in New York City this year to train as many science teachers as we can to pick up part of that as well as social studies teachers the following year.

Again, the issue is how many people can we pull into training?

When it comes to issues that deal with sensitive subjects—and AIDS is certainly one of that, because you are involving the issues of death and dying, and sexuality. Many of the more academic area's teachers are less comfortable than health teachers traditionally are in dealing with those topics. Some of them have been sent by their districts—science people and social studies people—to AIDS training already, even though our first step was with the health teachers in the system.

Again, we are tied up with time. We can train just so many people a day. As it is we train thousands each year and——

Mr. OWENS. But science teachers are being included?

Ms. ABELSON. They will be included as well as social studies teachers, as well as curriculum in the science area that will incorporate it so we will be able to give it to them rather than say, just introduce it but we will actually be developing curriculum and science and social studies areas.

Mr. OWENS. Dr. Jubb?

Ms. JUBB. Scientific facts definitely can be handled by the science teachers. When you are talking about human behavior and behavior change, I think we still have to go back to the people that have the background and can most easily and perhaps the best of all worlds going through the health people for the behavior change.

Ms. HUBBELL. In response to a couple of your comments, should AIDS education be part of sex education, or can you have one without the other?

Mr. OWENS. Does it have to be synonymous, I said.

Ms. HUBBELL. AIDS education in the eyes of the National Association and the State Association is that we want to teach our youth to have healthful bodies. AIDS education is a part of sex education. But right now the urgency is in the area of AIDS education

In my local district we currently are targeting this year our fifth, sixth, seventh, eighth graders and the sophomores in biology classes.

The training in our local State has been with the counselors, the health teachers, the home ec. teachers, the science teachers, and any of the other teachers that we feel will be involved in the education of AIDS.

Every teacher in every district must be educated because the student will go to whichever teacher they feel most comfortable with when they have a question about AIDS. So it is the intent to have every teacher trained in the area of AIDS by next fall. Those that are doing the specific teaching will have further training—those that are doing the curriculum development.

I just might say from the national level that the national level has the opportunity to work with the State policymakers to at least educate them on AIDS. The State policymakers, if they have the urgency and understand the need, then will impart that information to the local districts.

So I feel that that is where the Federal Government, CDC, the National Association of State Boards, can be most effective in the fact that they are the national policymakers who could hopefully in turn educate our State policymakers in the States that are not currently doing very much with AIDS education.

Mr. OWENS. Thank you very much.

Congressman Biaggi?

Mr. BIAGGI. Thank you.

Let me apologize first for not being present when you testified. Although I wasn't here, I had staff here. I attended two other such committees and meetings this morning. That's the way it functions here. I didn't realize you were going to be one panel.

I would also like to personally welcome Ms. Abelson from New York City.

You made some reference about desiring to study or determine the children's behavior. Isn't that a little difficult?

Ms. ABELSON. We can't, that's the problem.

Mr. BIAGGI. Pardon me?

Ms. ABELSON. We can't.

Mr. BIAGGI. I know.

You don't have them identified. In the City of New York you have, say, 1,000 infected children. What would you suggest?

Ms. ABELSON. What we were hoping to do is to be able to do a survey that would provide baseline data in terms of——

Mr. BIAGGI. How would you do that? You need numbers and you need identification.

Ms. ABELSON. If we have a mandated AIDS education program, that's begun. We begin to do baseline surveys right now on a random level in terms of—just youngsters in terms of their drug involvement, their sexual behavior, and then do repeated baseline surveys.

We cannot trail and trace particular youngsters. There's no issue in that. It is impossible in the city in terms of the turnover and the mobility of our youth as well as confidentiality.

But we can start seeing from baseline data, year after year, once a program is implemented and mandated, if there are indeed changes in that behavior, those behavioral responses within the baseline data.

Mr. BIAGGI. You are really talking about a lengthy process.

Ms. ABELSON. Absolutely.

Mr. BIAGGI. There's a sense of urgency here that requires an immediacy of attention. I am sure you would like to have that information as quickly as possible so that you can work with it.

How do you overcome the problem that we find; the identification of the children?

There's something wrong here. We are dealing with a very critical epidemic, a very critical disease, with a potential for human death that boggles your mind. And we are proceeding in the same normal, bureaucratic fashion. It is just inconsistent. It cries out for some departure from the norm.

Ms. ABELSON. That's one of the reasons I said earlier, that while the whole local control over this is very important and has worked in our family living sex ed programs and has engaged communities and parents in a very trusting relationship.

One of the things we have on a national, State and local level is the ongoing politicalization of this issue, and youngsters are dying in the meantime. That becomes to me a moral dilemma.

Mr. BIAGGI. Sure.

I think a number of you have stated that there is a conflict in the interpretations, in the guidelines. You say there is a conflict, if I understood you correctly.

Ms. ABELSON. I'm sorry?

Mr. BIAGGI. There isn't a conflict in the guidelines?

Ms. ABELSON. No, what I am saying is——

Mr. BIAGGI. I'm on another subject now.

Ms. ABELSON. I'm sorry. Could you clarify?

Mr. BIAGGI. We are talking about some Federal guidelines and the local guidelines and——

Ms. ABELSON. What I am saying is that our leaders at the Board of Ed are actually a New York City Department of Health. They in interaction with the members of the Board of Ed develop policy. In relationship to that local control, any Federal guidelines that come down go through a local level of review and for the policy statements.

I haven't been privy to reviewing those guidelines so I am not saying that they are in conflict or not—I just don't know. I am just saying it is another level of review and it's establishing policy on the local city level.

Mr. BIAGGI. What prompts me to ask the question was a special report I read which said some systems work out beautifully, others are nightmares.

Now, why?

Ms. ABELSON. In New York City the whole program of decentralization of school districts.

Mr. BIAGGI. But New York City is not the Nation, I understand that.

I would like to hear from others.

Ms. HUBBELL. I am not familiar with any conflicts in the guidelines that have been distributed from CDC, from the health and environment, from the national organizations to the State. I am not familiar with conflict.

I believe what we were saying, though, is the local school boards in those States have the final decision on what is actually taught and who receives that instruction. But as far as guidelines that have been prepared nationally I am not aware of conflicts with the way the State of Kansas interprets those guidelines and policies versus what the nationals have suggested.

Mr. BIAGGI. Then one would have to conclude that the local school districts make their own determination, and depending upon their determination you find the success or failure of the process. So that calls for something else, doesn't it? Could we permit a local school district to not comply or to construe the guidelines in a fashion that doesn't serve our ultimate end?

Ms. JUBB. I think the funded agencies will be playing a major role in this because it is an education process to get to the administrators at the State level—if it's school boards, if it's principals association, if the school of nurses, whichever group that this national funded organization is being able to assist by educating need for quickness, effective programs, and that is then passed down, really, to the local level. That's how we can assure effective programs at the local level.

Ms. FRASER. Mr. Biaggi, my name is Katherine Fraser. I am from the National Association of State Boards of Education.

We recently did a survey on States and there are conflicts between what national organizations are recommending and what local districts are doing. But as Dr. Jubb is saying——

Mr. BIAGGI. Would you get closer to that mike?

Mr. OWENS. You may take a seat and please identify yourself. You are accompanying Ms. Hubbell?

Ms. FRASER. Yes, I am accompanying Ms. Hubbell. I am from the National Association and she sits on the Board of Directors.

Mr. OWENS. The name again?

Ms. FRASER. Katherine Fraser.

Mr. OWENS. Proceed.

Ms. FRASER. I just wanted to say that the results of our survey showed that what local districts are doing does not necessarily reflect what national organizations or the CDC is recommending. That is the challenge to us is to provide local districts with this information, what the latest research is on programs that show promise in changing students' attitudes and behaviors; to give them the latest up-to-date information about AIDS; to create networks so that they can have access to this information quickly. Policies for handling students and staff are complicated by legal issues, civil rights issues, medical issues, and local districts don't necessarily have access to the time of the staff to sort through all of these.

So our challenge is to provide that to the local districts.

Mr. BIAGGI. So clearly there is some conflict?

Ms. FRASER. Certainly.

Mr. BIAGGI. To pursue that, and the cause, then how do we get the local districts in a position to do the job as prescribed by the guidelines?

Ms. FRASER. We believe in strong State leadership such as has been provided by Connie Hubbell who talked to you before. She has been a very strong advocate for AIDS education statewide. She has courageously stood up in forum after forum and talked about AIDS—educated people—talked about the need for education, soothes people's fears.

Look, we are not in the process of encouraging your children to do things that you don't want them to do, and we don't want to give them information that you are opposed to. What we are in-

volved in is a struggle to present information about the disease in a way that you can support.

So we believe in the State leadership.

Mr. BIAGGI. Thank you. I want to thank you very much, because something was glaring in this whole presentation.

Let me ask you one question and be as candid as you can. Is this a bureaucratic or governmental response that is a traditional one, to a problem that faces us in the Nation; or do you get the feeling, down deep in your heart of hearts, that this is an issue that really is being responded with genuine urgency?

Maybe you should write and put in a piece of paper without your names on it. [Laughter.]

That's the question.

Ms. HUBBELL. I feel in our State it has definitely been a genuine urgency, and it has not been because any Federal person told us we must do it because we knew we had to do something.

Mr. BIAGGI. I think that is wonderful. That is the way it should be.

Ms. HUBBELL. In a midwestern State that is not a high epidemic State, we realized in Kansas that we had to do something before we had an epidemic there. So I would say very genuinely it was a decision made out of the ordinary, very quickly, that we had to attack it now before it got any worse.

Mr. BIAGGI. Dr. Jubb?

Ms. JUBB. Michigan began with an urgency. We were working with the Michigan Department of Public Health, who also identified it as a health emergency. I believe working together we accomplished more. I also feel that at the Federal level, putting AIDS education into a comprehensive health program is a lot better way to go than saying we have now got another problem and isolating it, like we have done with some of our health problems in the past.

Mr. BIAGGI. I want to thank you.

Ms. Abelson?

Ms. ABELSON. I do think when it started it was responded to as a sense of urgency. There was certainly no pressure from the State or the Federal Government at the time when the program was mandated.

I think as the funding dollars start coming through the community and the school, and as the realities of actually expanding this program takes place, it gets mucked down in bureaucratic struggles as well as fighting with who gets the dollars and where do they have to go instead of spreading it out and working together.

Mr. BIAGGI. Thank you for your responses and candor. Thank you for your contribution.

Thank you, Mr. Chairman.

Mr. OWENS. Congressman Sawyer?

Mr. SAWYER. Thank you, Mr. Chairman.

I want to take this moment to thank you for the work you have done in putting these hearings together. It is clear that at a time when the incidence of this disease is spreading exponentially that education is really our only first line of defense.

It is particularly disturbing—and not speaking of the folks who are with us today, or to you—but the less than stellar record that we have had as a Nation in dealing with health threats, it is par-

ticularly gratifying to see the testimony and guidelines prepared by the Centers for Disease Control.

I think it is just absolutely clear that there is little choice but to act immediately. I feel as though we are almost preaching to the choir. We have declared war. We have recognized that the war is enormously important, and then we have asked for volunteers among the local police forces and the State militias. Some have responded, but many have not.

If my figures are correct, we have got some 27 States who are currently responding with curricula that include discussion of health-threatening behaviors in the broadest terms, and maybe 18 or so that really have included responsible AIDS curriculum in their overall offerings. That is just not enough.

At a time when we are looking at the importance of the diversity of our educational system across the country and the need to reflect the benefits we can derive from experimentation in various educational techniques that are responsive to local needs, I still hear in the background in every one of your comments—regardless of that need for flexibility—a plea for firmness as we ask the States to begin to take action. And without that firmness, that those who have conscience at a local level who understand as you do the need to act may not have the backing necessary to build the community support necessary to carry it out. That is just a comment.

I particularly appreciate the testimony that you have all offered. I have got a couple of very specific questions I wanted to ask.

Mr. Tolsma, you mentioned on page 2 of your testimony the importance of undertaking expanded HIV surveillance which could provide insights about heterosexual spread. Can you expand on this and tell us what you are looking for exactly, and what is HIV surveillance?

Excuse me—it is a critical question if it is what I suspect it is.

Mr. TOLSMA. The program that you described, we have talked about it as a family of surveys being undertaken in 30 cities, many with high incidence of AIDS, and some as well with low incidence of AIDS.

We don't have adequate information today on what are the prevalence levels in various groups at risk in the population.

I have with me Dr. Peter Drotman from the Center for Infectious Diseases, a medical epidemiologist. Perhaps I could ask him to very briefly describe to you the kind of information we are trying to get.

Dr. DROTMAN. One of the major responsibilities of the Centers for Disease Control is to investigate epidemics of all sorts in this country and to identify their cause and the risk factors for affliction with the epidemic diseases and methods of intervention and prevention.

When AIDS was first discovered—recognized in the United States back in 1981, it was the severest manifestations, the life-threatening infections and cancers that we have all heard so much about, that were discovered first. It was several years later that the actual virus that underlies these multiple problems now called HIV—human immunodeficiency virus—was described.

The condition that is reportable in all States is the first recognized severe AIDS disease. Clearly to prevent AIDS we need to pre-

vent HIV infection. This is reportable only in a few States. The tools to recognize HIV infection—blood tests and perhaps other laborabory tests which are not yet available; blood tests have only been available for the last two years or so—three years now.

So we want to encourage the expanded use of these tests to identify the greater part of the problem, which is HIV infection, but not yet causing actual disease. To do this requires considerable effort and cooperation, not only on the part of physicians and health departments, but also the afflicted communities and the infected people need to come forward to be tested and identified, receive specific counseling and interventions.

Some of these people are difficult to reach. Some of them are fearful that if identified they will suffer social stigmatization and other problems related with prejudice, and housing, and job opportunities, and so on.

So accomplishing these studies and gathering data about the true incidence of this infection in our country has been quite a challenge. We intend to overcome that in a variety of ways: by guaranteeing anonymity, using blood that is collected for other purposes, and eradicating any identifying information, and then testing for public health purposes only, not for identifying people.

This will be done in many geographic areas with many different groups of subjects.

Mr. SAWYER. Even the preliminary reports that have come in from that—I think you mentioned in your testimony, Mr. Tolsma, the enormous expansion in the presumed level of infection. It may be as many as a million or million-and-a-half incidences.

If those figures are as high as they appear to be, does that begin to alter your view about the kinds of strategies that are involved in your recommended approach, and the conclusions that you have arrived on in your testimony today, and the strategies we have taken so far?

Mr. TOLSMA. It is perhaps those figures that tell us how important it is to focus not only on areas where there is already high risk but on those parts of the country where risk is still low, because there is still time to prevent that number from growing really much larger.

So when a State like Kansas, for example, takes the action it does, it is not taking it because it currently has a high level of HIV. It is taking it because they, too, know that this virus will not pay any attention to a State boundary.

What I think it means is that one of the fundamental tenets of health education is that we cannot treat education as a vaccine. Education is not a one-shot enterprise. There needs to be multiple messages, through multiple channels, and repeated multiple times; certainly with people who are not yet at risk, which the great majority of our young people, fortunately, are not at this point at risk. They are in a developmental stage in their life where they are making a variety of health choices. Some have nothing to do with AIDS. They are choosing whether or not they will be cigarette smokers, for example, which has an important effect on their future health.

A comprehensive approach to school health education is not then simply an AIDS course. It is in a broader context of protective be-

havior. For example, the concept of self-esteem was brought up earlier—is probably a critical underlying issue to whether young people are going to be willing and motivated to take care of themselves. But peer resistance and peer resistance skills are something that can be taught. We can teach a child how to use a saw in a shop course and we can teach a child how to handle his or herself in the context of their peers.

Wanda Jubb doesn't know it, but my first job out of college was as a high school teacher in a rural community in Michigan. I now have a 13-year-old—and nothing has changed in the ensuing 23 years.

The importance of peers in young people's life is extraordinary. So the ability to say no in a way that doesn't make you an outcast, or make you perceive yourself as I will be an outcast if I don't say no. These are skills and they can be taught.

I think the vast majority of young people need to understand that they need not ever be at risk of AIDS, and that there are ways for them to prevent themselves from ever being at risk of AIDS.

Just to elaborate on one more aspect of what you said—the reason the CDC approach to health education and risk reduction is a comprehensive one is that each of these different target audiences have different and important educational needs. The general public needs to understand this disease. Ninety-nine percent of the people in the Nation have heard of AIDS. It is an extraordinary penetration of a concept.

But as one begins to understand what they know about AIDS, they often have very fundamental misconceptions. Dr. Jubb referred to the survey of students' needs that she has done.

There are only three published surveys at this point in the literature, and each documents important misperceptions about how AIDS is transferred. So as we go through each of the risk groups—those who are already at risk, those who are infected—those who are infected need to also change their behaviors so as not to further spread the infection to others, and that is part of the State health departments programs.

So I think what we need to do is understand that there are many groups in society who need education, and there are different types of education, and that is driven by knowledge of who is currently infected and who is currently at risk.

Mr. SAWYER. Let me share with you a perception—I would appreciate it if you would comment on.

Note that not every person infected with the AIDS virus becomes ill. This is characteristic of most infectious diseases. Most people exposed to a virus would not develop the disease, while the smallest percentage of persons exposed to the virus would become seriously ill.

Could you comment on that as a description of current understanding of AIDS?

Dr. DROTMAN. We have studied cohorts of men who have become infected with the AIDS virus to follow them over periods of time to determine a natural history of infection with this virus. Unfortunately, this infection is not treatable and it is not curable with any medical intervention at this point.

The outcome, of course, is of great importance to the hundreds of thousands, and perhaps more than a million, Americans who are already infected with this virus, and that question of what is the prognosis is of crucial importance to their futures.

The group of men that we have followed for the longest period of time, which is now seven years, is a cohort of gay men in San Francisco that we studied in conjunction with the health department in that city.

The outcome so far is that within the first two years of being infected, very few, virtually zero percent of the men, actually developed life-threatening AIDS.

But from two years onwards, about five percent per year developed AIDS. So that by the time this group of men has been observed for seven years totally, about a third—or in the 35 percent range—have been diagnosed with AIDS; and a large fraction of them, unfortunately, have died.

The rest—the other 65 percent or so—many of them have some symptoms—a lymph gland enlargement, fever, weight loss, some of these symptoms that you have probably heard about. A small fraction of them—about 15 percent—have absolutely no symptoms and appear to be in good health. But they are still infected with the AIDS virus, even seven years later.

Now what will happen to this group of men who do not yet have AIDS or do not have AIDS, over the next seven years, and the seven years after that, is not known and not readily predictable by the previous pattern.

It is almost assured that some more of them will get AIDS, but what percentage that will be is not reliably predictable.

Mr. SAWYER. In the sense that those outcomes really are not known, would you agree that that is a remarkably dangerous assertion to be teaching young children at this point?

Dr. DROTMAN. There's no question that infection with HIV is serious and has a very high risk of progression to a disease that is not treatable at this time. I don't know the context in which that quotation appears.

Mr. SAWYER. It is part of the currently used or Department of Health AIDS virus informational package that is used in preparing curricula. This is not to criticize it; it is to say that the difficulty in keeping pace with the rapidly changing character of information that we have got is something that may not be sufficient for which volunteer activities may not be sufficient.

We really need, it seems to me, to do a great deal more in terms of sharing current state of knowledge with those who are developing curricula, and that while the way in which that information is shared in the classroom really does remain a matter of local control. But it is critically important that we do more than leave that to some 18 States—I hope the number grows—that makes use to take up the banner.

I am really concerned about whether or not we as a Federal Government need to look at the way in which we provide support to health and education institutions on the State and local level, in a broader context, so that it is not left to the cultural diversity of this enormous country, but rather, the real and measurable needs

of a disease whose infection levels are beyond our ability to measure right now.

Thank you, Mr. Chairman.

Mr. OWENS. Again I want to thank all of our panelists. What you have said today we find very useful. A number of pieces of legislation are being proposed in this area. As I mentioned in my opening statement, there are currently a number of pieces that are already in the process, so your information has been very useful.

Your written testimony certainly will be included in the record in its entirety. If you have additional information that you would like to submit in the next 10 days we would be happy to receive that also for the record. Thank you again.

The hearing is now adjourned.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]